

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15446

15446

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE ILLINOIS b. COUNTY COOK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHICAGO	
c. LENGTH OF STAY IN 1b 1 WEEK		d. STREET ADDRESS 5051 N. GLENWOOD AVE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CARROLL COUNTY GEN. HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CLARA ELIZABETH ANDERSON		4. DATE OF DEATH Month Day Year 11 3 1966	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 7, 1877
9. AGE (In years lost birthday) 89 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE-WIFE	
11. BIRTHPLACE (County & State, or foreign country) COPENHAGEN DENMARK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILHELM LINDORFF		14. MOTHER'S MAIDEN NAME MARIAN LARSEN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) >		16. SOCIAL SECURITY NO. >	
17. INFORMANT ELMER O. ANDERSON		Address WESTMINSTER, MD. RT. #4	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC LYMPHOCYTIC LEUKEMIA 2040 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE - (c) 2040 DUE TO			INTERVAL BETWEEN ONSET AND DEATH 1 MOS. YRS.
PART II. OTHER SIGNIFKANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) BRONCHO PNEUMONIA - BILATERAL			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/27, 1966 to 11/3, 1966 , that (I) (we) last saw the deceased alive on 11/3, 1966 , and that death occurred at 12:45 M, from causes and on the date stated above.			
22a. SIGNATURE Vincent J. Fiocco Jr.		22b. DATE SIGNED 11/13/66	
22c. PHYSICIAN'S NAME (Type) VINCENT J. FIOCCO, JR.		22d. ADDRESS WESTMINSTER, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE THEREOF 11/14/66	23c. NAME OF CEMETERY OR CREMATORY GRACELAND CEMETERY	23d. LOCATION (City or town) (County) (State) CHICAGO ILLINOIS
24. FUNERAL DIRECTOR J. S. Myers Jr. Westminster, Md.		25a. REC'D BY REGISTRAR DATE NOV 7 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

1922-23

1927-28 1928-29

1950-1951 1952-1953

CHRYSLER CREDIT

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15447

CERTIFICATE OF DEATH

15447

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville		c. LENGTH OF STAY IN 1b 9y 3m 26d	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		d. STREET ADDRESS 6005 Cedonia Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thurman (H. -) Arnold		4. DATE OF DEATH Month 11 Day 22 Year 19 66	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-26-1893
9. AGE (In years last birthday) yrs. 73		10. IF UNDER 1 YEAR Months - Days - Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Arnold (step-father)		14. MOTHER'S MAIDEN NAME Margaret Sheppard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. 215-09-3708	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral suppurative nephritis DUE TO (c) -		INTERVAL BETWEEN ONSET AND DEATH 6000 Days - Weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with psychotic reaction.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) -	
20c. TIME OF INJURY Month, Day, Year Hour a.m. - p.m. - 19 -		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -		20f. (City or town) (County) (State) -	
21. I certify that (1) (this hospital) attended the deceased from 7-25 , 19 57 , to 11-22 , 19 66 , that (1) (we) last saw the deceased alive on 11-22 , 19 66 , and that death occurred on 11-22 , 19 66 , from causes and on the date stated above.			
22a. SIGNATURE Heinz H. Klaatsch		22b. DATE SIGNED 11-22-66	
22c. PHYSICIAN'S NAME (Type) Heinz H. Klaatsch, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removed		23b. DATE THEREOF 11-26-66	
23c. NAME OF CEMETERY OR CREMATORY Saint John's Cemetery		23d. LOCATION (City or Town) (County) (State) Ellicott City, Md.	
24. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Road 21206		25a. REC'D BY REGISTRAR NOV 23 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1941

TECHNICAL



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15448

CERTIFICATE OF DEATH

15448

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle Lydia Last Bair		4. DATE OF DEATH Month 11 Day 18 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1885
9. AGE (In years lost birthday) yrs. 81		10. IF UNDER 1 YEAR Months 11 Days 18 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (County & State, or foreign country) Carroll County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abraham Hahn		14. MOTHER'S MAIDEN NAME Amanda Ellen Sowers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Kenneth A. Bair, Taneytown, Maryland	
17. INFORMANT Kenneth A. Bair, Taneytown, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 14 HRS YRS.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		20f. (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/18 , 19 66 , to 11/18 , 19 66 , that (I) (we) last saw the deceased alive on 10/18 , 19 66 , and that death occurred at 10:30 M, from causes and on the date stated above.			
22a. SIGNATURE Vincent J. Fiocco		22b. DATE SIGNED 11/18/66	
22c. PHYSICIAN'S NAME (Type) Vincent J. Fiocco		22d. ADDRESS 8 Anchor Street, Westminster, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 21, 1966	
23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		23d. LOCATION (City or Town) (County) (State) Taneytown, Carroll, Maryland	
24. FUNERAL DIRECTOR C.O. Fuss & Son, Taneytown, Md.		25. REC'D BY REGISTRAR NOV 21 1966	
25a. REGISTRAR'S SIGNATURE Charles J. J...		25b. REGISTRAR'S SIGNATURE Charles J. J...	

3322

2151

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15449

CERTIFICATE OF DEATH

15449

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster c. LENGTH OF STAY IN Tb 20 Years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Westminster, Md. R. D. 2				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster d. STREET ADDRESS Westminster, Md. R. D. 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Lester Lammis Barnhart (Barnhart) 4. DATE OF DEATH Month Day Year Nov. 2 1966				5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 8/1/1901 9. AGE (In years last birthday) 65 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Shoe Worker 10b. KIND OF BUSINESS OR INDUSTRY Shoe Factory 11. BIRTHPLACE (County & State, or foreign country) Carroll County, Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John H. Barnhart 14. MOTHER'S MAIDEN NAME Elizabeth Richman				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 213-05-1217 17. INFORMANT Nettie M. Barnhart Address Westminster, Md. R-2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary Emphysema						INTERVAL BETWEEN ONSET AND DEATH unknown 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 8-17, 1964, to 9-12, 1964 that (I) (we) last saw the deceased alive on 9-12, 1964, and that death occurred at 8:30 A.M. from causes and on the date stated above. 22a. SIGNATURE <i>Philip W. Mercer</i> M.D. 22b. DATE SIGNED 11-2-66 22c. PHYSICIAN'S NAME (Type) Philip W. Mercer 22d. ADDRESS 150 W. Main St. Westminster, Md. 22e. MED. DIRECTOR <input checked="" type="checkbox"/> 22f. STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 11/5/66 23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery 23d. LOCATION (City or Town) (County) (State) Silver Run, Carroll Co., Md. 24. FUNERAL DIRECTOR <i>Richard A. Little</i> ADDRESS Littlestown, Pa. 25a. REC'D BY REGISTRAR NOV 4 1966 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							

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02181

UNITED STATES DEPARTMENT OF THE ARMY

OFFICE OF THE ADJUTANT GENERAL

REPORT

NO. 1

REPORT

1. NAME OF THE PERSON OR PERSONS

2. GRADE OR POSITION

3. TITLE OF THE REPORT

4. DATE OF THE REPORT

5. PLACE OF THE REPORT

6.

7.

8.

9.

10.

11.

12.

13.

14.

15.

16. NAME OF THE PERSON OR PERSONS

17.

18. NAME OF THE PERSON OR PERSONS

19. GRADE OR POSITION

20. DATE OF THE REPORT

21. PLACE OF THE REPORT

22.

23.

24.

FOR STATE
HEALTH DEPT.

15450

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15450

1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN lb ?		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CARROLL COUNTY GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 06.1 Taylorsville Rural-Mt. Airy	
3. NAME OF DECEASED (Type or print) First LILY Middle E. Last BRIGHTWELL		4. DATE OF DEATH Month November Day 27 Year 19 66			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15, 1902	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Worcester, Mass.	
13. FATHER'S NAME Frank F. Carlstrom		14. MOTHER'S MAIDEN NAME Augusta H. Islau		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-14-9536B		17. INFORMANT Mr. Wm. Clifford Brightwell Address Same As #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries 8164 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car in auto-auto collision			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11:00 p.m. 11-27 19 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	
		20f. (City or town) Carroll (County) Md. (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate M.D.		22. DATE SIGNED November 28, 1966		22. DATE SIGNED	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/30/1966		23c. NAME OF CEMETERY OR CREMATORY Linganore Cemetery	
		23d. LOCATION (City or Town) Frederick Co., Md. (County) (State)			
24. FUNERAL DIRECTOR C. M. Waltz		ADDRESS Box 241 Sykesville, Md.		25a. REC'D BY REGISTRAR DEC 1 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15450

100000

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15451

CERTIFICATE OF DEATH

15451

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admision) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville - Rural -		c. LENGTH OF STAY IN 1b 2 mo. 1 day.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 1956 Seminary Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Antolina Gertrudis Rojas Cabarga		4. DATE OF DEATH Month 11 - Day 27 - Year 1966	
5 SEX female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2-6-1877.
9 AGE (In years last birthday) 89 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Cuba	
13 FATHER'S NAME Amador Rojas		14. MOTHER'S MAIDEN NAME Isabel Gallardo	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Springfield Hosp Medical Records, Md.		Address Sykesville	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Terminal Pneumonia DUE TO (b) Congestive Heart Failure DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from 9-26 , 19 66 , to 11-27 , 19 66 , that he (we) last saw the deceased alive on 11-27 , 19 66 , and that death occurred at 11:35am on 11-27 , 19 66 , and on the date stated above.			
22a. SIGNATURE Renato R. Espina		22b. DATE SIGNED 11-27-66	
22c. PHYSICIAN'S NAME (Type) Renato Espina, M.D.		22d. ADDRESS Springfield State Hospital Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried	23b. DATE THEREOF Nov 29, 1966	23c. NAME OF CEMETERY OR CREMATOR Int Christ Cemetery	23d. LOCATION (City or Town) (County) (State) Washington D.C.
24 FUNERAL DIRECTOR F Knack's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE NOV 30 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 12 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BP

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15452 CERTIFICATE OF DEATH 15452

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Emory</u> c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Golden Age Duet Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Upperco</u> d. STREET ADDRESS <u>Emory Church Road</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Last: Carr Middle: Bradley First: Thomas</u>		4. DATE OF DEATH <u>Nov 23 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/17/83</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Carr</u>		14. MOTHER'S MAIDEN NAME <u>Annie Iglehart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-36-7941</u>	
17. INFORMANT <u>Mrs. Eleanor Carr, Upperco, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Spontaneous Coronary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Cholesterol Hypertension</u> DUE TO (c) <u>Small Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 31, 1966</u> to <u>Nov 23, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov 22, 1966</u> , and that death occurred at <u>3:40</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>M. M. MARTIN</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/26/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Emory Methodist Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Carroll Co. Md.</u>
24. FUNERAL DIRECTOR <u>Tipton-Eline Funeral Home, Hampstead, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 23 1966</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 15453

1. PLACE OF DEATH e. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 33yrs. 7mos. 1dys.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS Rural	
3. NAME OF DECEASED (Type or print) CATTERTON, Essie		4. DATE OF DEATH Month NOVEMBER Day 29 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-18-1876
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR: Months 11 Days 29 Hours 00 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Catterton		14. MOTHER'S MAIDEN NAME Mary A. (last name unk.)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-54-6633	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia by occlusion of larynx with peanut butter 7d. 7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) due to (c) due to PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epileptic psychosis.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH minutes	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) patient was eating supper & eating peanut butter with spoon. Patient was patient's tray slip to floor & she seemed to be choking.	
20c. TIME OF INJURY Month, Day, Year Hour 6:10 a.m. 11-29 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Springfield State Hospital		20f. (City or town) (County) (State) Sykesville, Carroll Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. Glenn Speicher, M. D.		22. DATE SIGNED 11-29-66	
EXAMINER'S NAME (Type) W. Glenn Speicher, M. D.		Address (Street, city, town, or county) 1335 Maryland Avenue, Carroll, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 1, 1966	23c. NAME OF CEMETERY OR CREMATORY Friendship Ch. Cem	23d. LOCATION (City, town, or county) (State) Friendship, Md.
24. FUNERAL DIRECTOR Hutchins Funeral Home Owings, Md.		25a. REC'D BY REGISTRAR DATE 12 1966	
25b. REGISTRAR'S SIGNATURE [Signature]			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

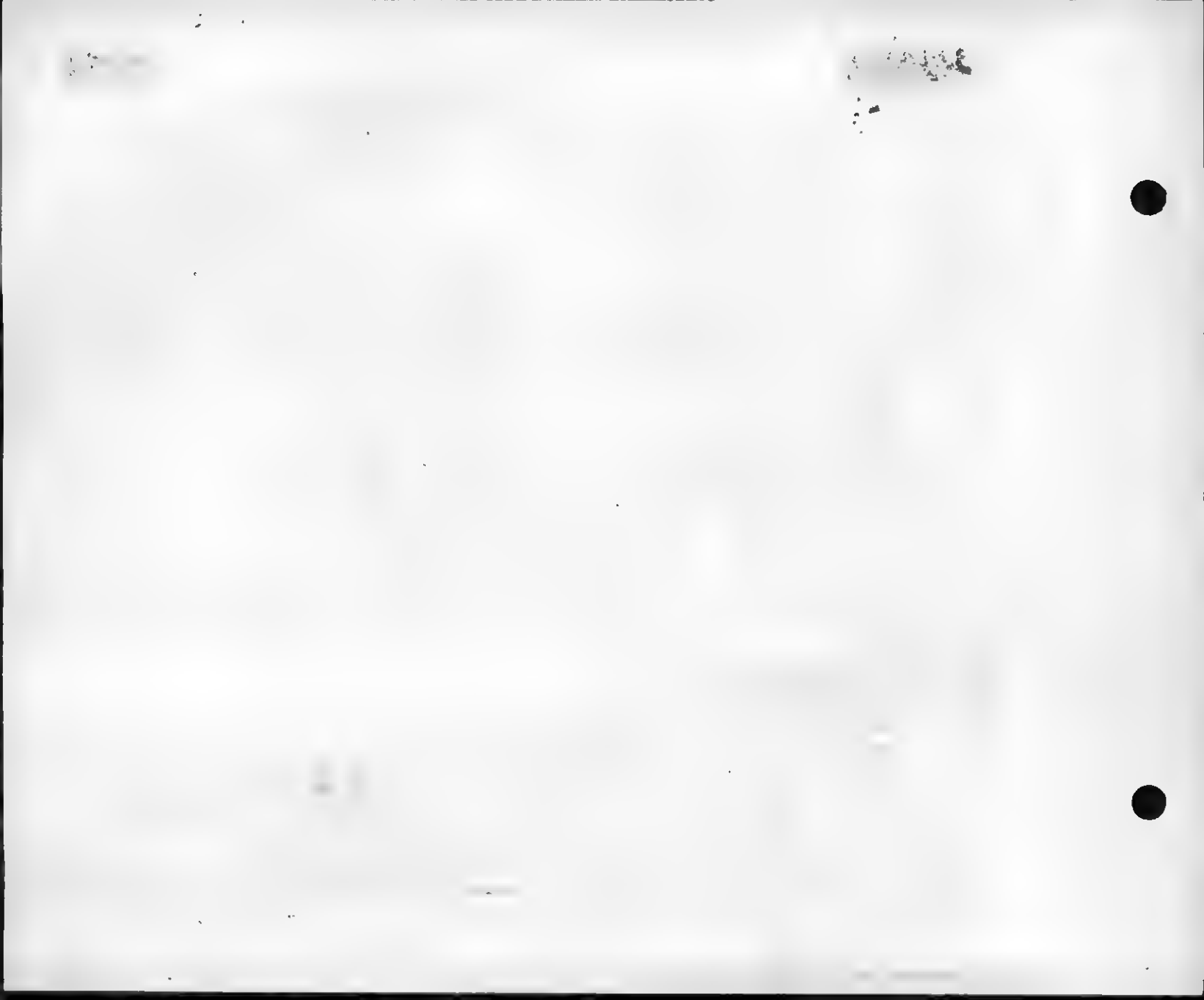
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15454

CERTIFICATE OF DEATH

15454

1 PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u>			
c. LENGTH OF STAY IN 1b <u>57 Years</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Amelia</u> Middle <u>Condon</u> Last <u>Condon</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>13</u> Year <u>1955</u>			
5. SEX <u>Female</u>	6. CO. OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 15, 1892</u>	9. AGE (In years last birthday) <u>74</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William O. Porter</u>				14. MOTHER'S MAIDEN NAME <u>Mary T. Pickett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Mrs. Mary Purdum Same As #</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V.D.</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid arthritis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/11/59</u> , 19 <u> </u> to <u>11/18/46</u> , 19 <u> </u> , that (I) was saw the deceased alive on <u>11/16/46</u> , 19 <u> </u> , and that death occurred at <u>5:30 P.M.</u> from causes and on the date stated above							
22a. SIGNATURE <u>W.E. Robertson</u>				22b. DATE SIGNED <u>11/18/46</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. I. B. Robertson</u>	
22d. ADDRESS <u>New Windsor, Md.</u>				22e. MED. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/21/1966</u>		23c. NAME OF CEMETERY <u>Morian Chapel</u>		23d. LOCATION (City or Town) (County) (State) <u>Carroll Co., Md.</u>	
24. FUNERAL DIRECTOR <u>C. M. Waltz Box 241 Sykesville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 22 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE
HEALTH DEPT.

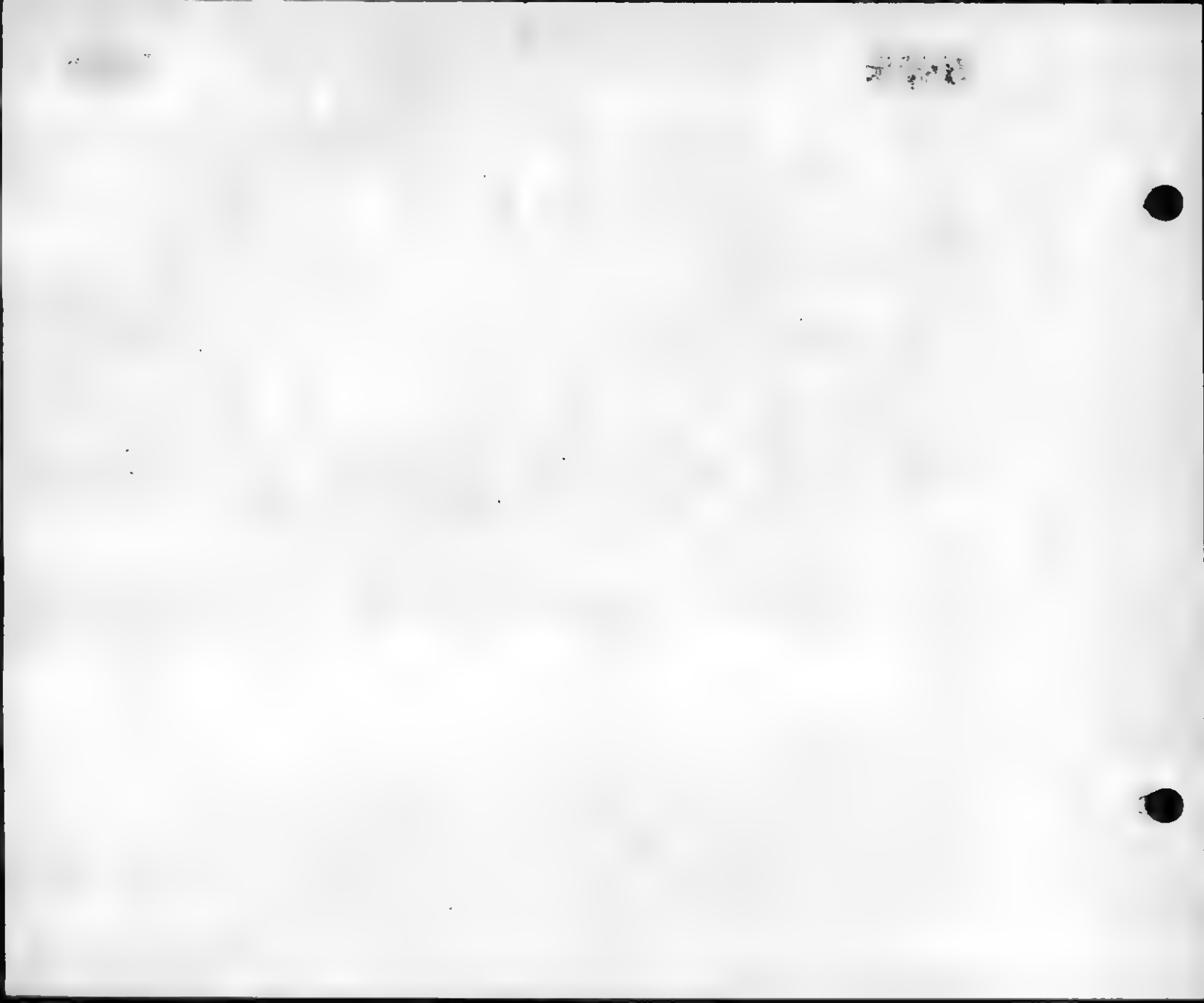
TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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3500 4-64

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>15455</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p> <p>15455</p> </div> </div>									
1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER c. LENGTH OF STAY IN 1b 8 YRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) POOLE ROAD					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER d. STREET ADDRESS POOLE ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) FORREST RAY COOK			4. DATE OF DEATH Month NOV. Day 15 Year 1966						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 10 1917		9. AGE (In years last birthday) 49 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WORKER STATE ROADS				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ALBERNE VILLE, VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LUTHER J. COOK					14. MOTHER'S MAIDEN NAME JULIA ANN SPROUSE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWII			16. SOCIAL SECURITY NO. 223-14-0416		17. INFORMANT MRS RUTH NELL COOK Address SAME ADDRESS				
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis (acute) sudden DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE W. L. Spencer EXAMINER'S NAME (Type)				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 135 E. Main St. Westminister, Carroll				22. DATE SIGNED 11-15-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/18/66		23c. NAME OF CEMETERY OR CREMATORY ABERENE CEMETERY		23d. LOCATION (City, town or county) ABERENE LA.			
24. FUNERAL DIRECTOR J. S. Murphy, Westminister, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE NOV 17 1966		25b. REGISTRAR'S SIGNATURE Charles J. J...	

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

15456

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15456

1 PLACE OF DEATH a COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE Maryland b COUNTY Carroll	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville-rural		c LENGTH OF STAY IN 1b Life	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RD #1		d STREET ADDRESS RD #1	
3 NAME OF DECEASED (Type or print) First Middle Last Wakeman Cook		4 DATE OF DEATH Month Day Year 11 13 19 66	
5 SEX male	6 COLOR OR RACE colored	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sent. 12, 1905
9 AGE (in years last birthday) 61		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm labor		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Carroll Co., Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Grant Cook		14 MOTHER'S MARDEN NAME Emma Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 213-12-8684	
17. INFORMANT Bartholomew M. Rt. 3		Address Mrs. Goldie Parks Sykesville, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary embolism following 11 d 1 DUE TO fractures of femur and pelvis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Pedestrian struck by tractor	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. ? 8 18 1966		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm
20f. (City or town) (County) (State) Sykesville-rural Carr. Md.			
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22. DATE SIGNED 11/14/66	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/17/1966	23c. NAME OF CEMETERY OR CREMATORY White Rock Cemetery	23d. LOCATION (City or Town) (County) (State) Carroll Co., Md.
24. FUNERAL DIRECTOR C. L. Waltz Box 241 Sykesville, Md.		25a. REC'D BY REGISTRAR NOV 16 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if city delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

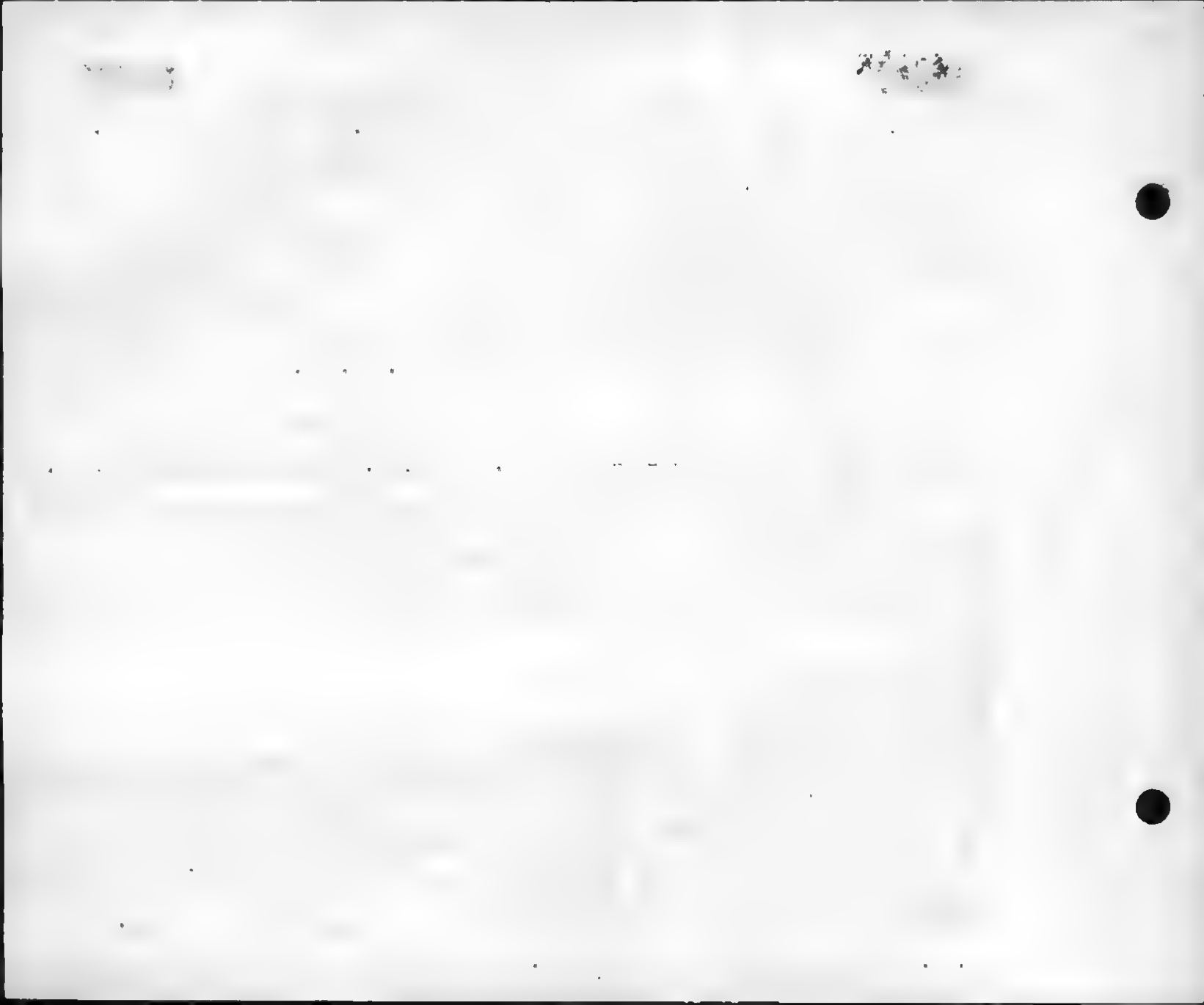
15457

15457

1 PLACE OF DEATH a COUNTY <u>Carroll</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) o STATE <u>Md.</u> b COUNTY <u>Balto.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c LENGTH OF STAY in 1b <u>Reisterstown</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Golden Age Guest Home</u>		d STREET ADDRESS <u>Glen Falls Road</u>	
3 NAME OF DECEASED (Type or print) <u>Edith G Cooper</u>		4 DATE OF DEATH <u>Nov 18 1966</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 13, 1882</u>
9 AGE (In years last birthday) <u>84</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired from May Company</u>		10b KIND OF BUSINESS OR INDUSTRY <u> </u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Balto. Co. Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Ensor</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Harmon</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>217-01-8490</u>	
17 INFORMANT <u>Mr. Carroll M. Cooper</u>		Address <u>Reisterstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Genl Anterior Sclerosis</u> DUE TO <u>Chro-Cardiac</u> (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>7</u> <u>2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>June 1, 1966</u> to <u>Nov 18, 1966</u> that (I) (we) last saw the deceased alive on <u>Nov 17, 1966</u> and that death occurred at <u> </u> M, from causes and on the date stated above.			
22a SIGNATURE <u>M N Martin</u>		22b. DATE SIGNED <u>Nov 18, 1966</u>	
22c PHYSICIAN'S NAME (Type) <u>M N MARTIN</u>		22d ADDRESS <u>Reisterstown, Md</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>11/21/66</u>	23c NAME OF CEMETERY OR CREMATORY <u>Middletown Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Freeland Md.</u>
24 FUNERAL DIRECTOR <u>J. F. Eline & Sons</u>		25a REC'D BY REGISTRAR <u>Nov 22 1966</u>	
ADDRESS <u>Reisterstown, Md.</u>		25b REGISTRAR'S SIGNATURE <u>John Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

15458

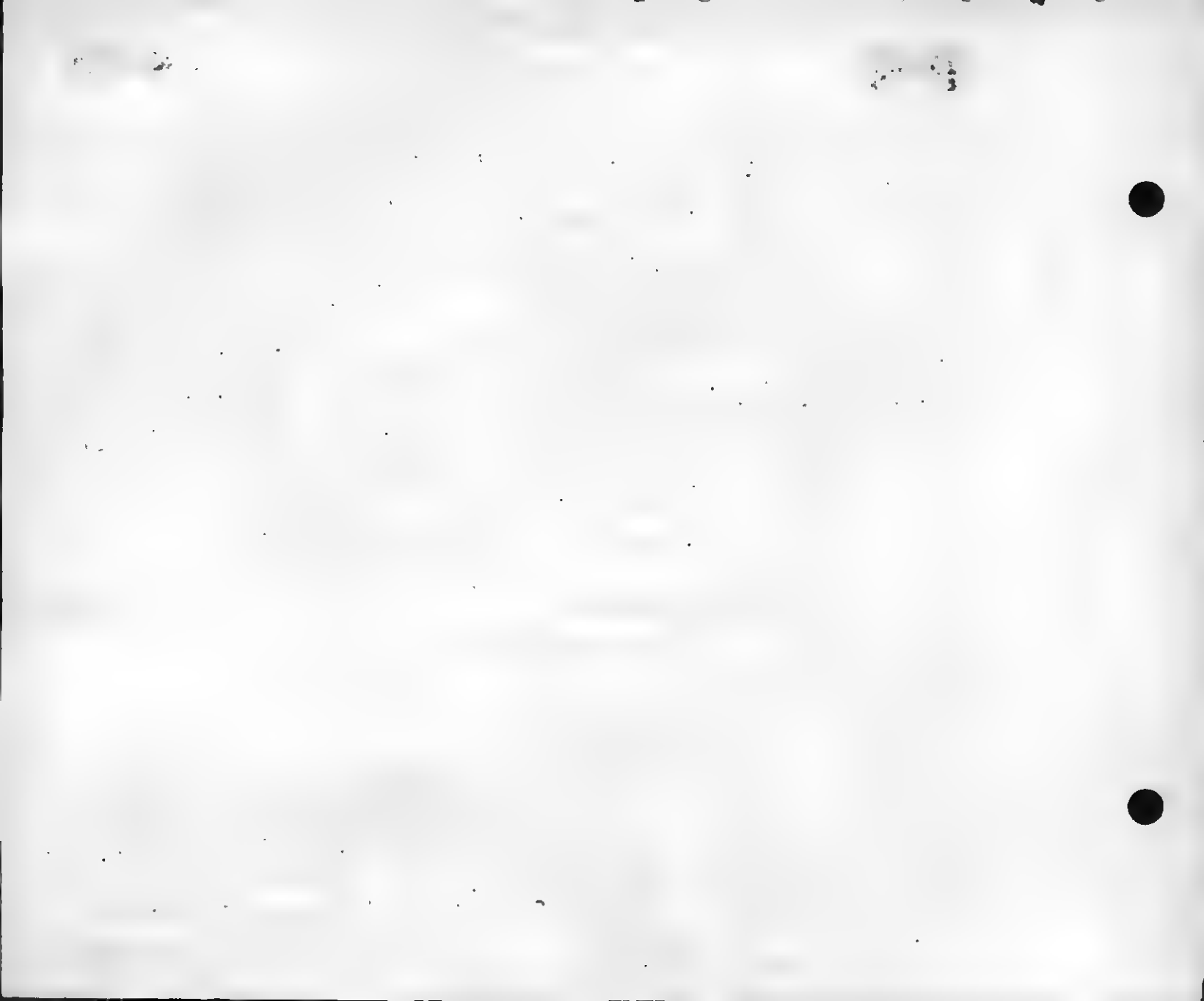
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15458

1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SYKESVILLE c. LENGTH OF STAY IN 1b 13 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRINGFIELD STATE HOSP.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE CITY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE CITY d. STREET ADDRESS 3826 HICKORY AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) David Henley CRAMER SR		4. DATE OF DEATH 11 16 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-22-92
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Line man		9b. AGE (in years last birthday) 74 yrs.	
10a. BIRTHPLACE (County & State, or foreign country) BALT. CITY - MARYLAND		10b. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. FATHER'S NAME ALFUS CRAMER		12. MOTHER'S MAIDEN NAME SARAH Henley	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		14. SOCIAL SECURITY NO. 212-05-6932A	
15. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) 		16. INTERVAL BETWEEN ONSET AND DEATH 3 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-3 , 19 66 to 11-16 , 19 66 that (I) (we) last saw the deceased alive on 11/16 , 19 66 , and that death occurred at 6:45 M, from the causes and on the date stated above.			
22a. SIGNATURE Samuel P. Wise III		22b. DATE SIGNED 11-16-1966	
22c. PHYSICIAN'S NAME (Type) SAMUEL P. WISE III		22d. ADDRESS S.S. Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 11-19-66	
23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cem		23d. LOCATION (City, town or county) (State) Towson Md	
24. FUNERAL DIRECTOR ADDRESS Burgess Funeral Home 3631 Falls Rd Baltimore		25a. REC'D BY REGISTRAR NOV 21 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

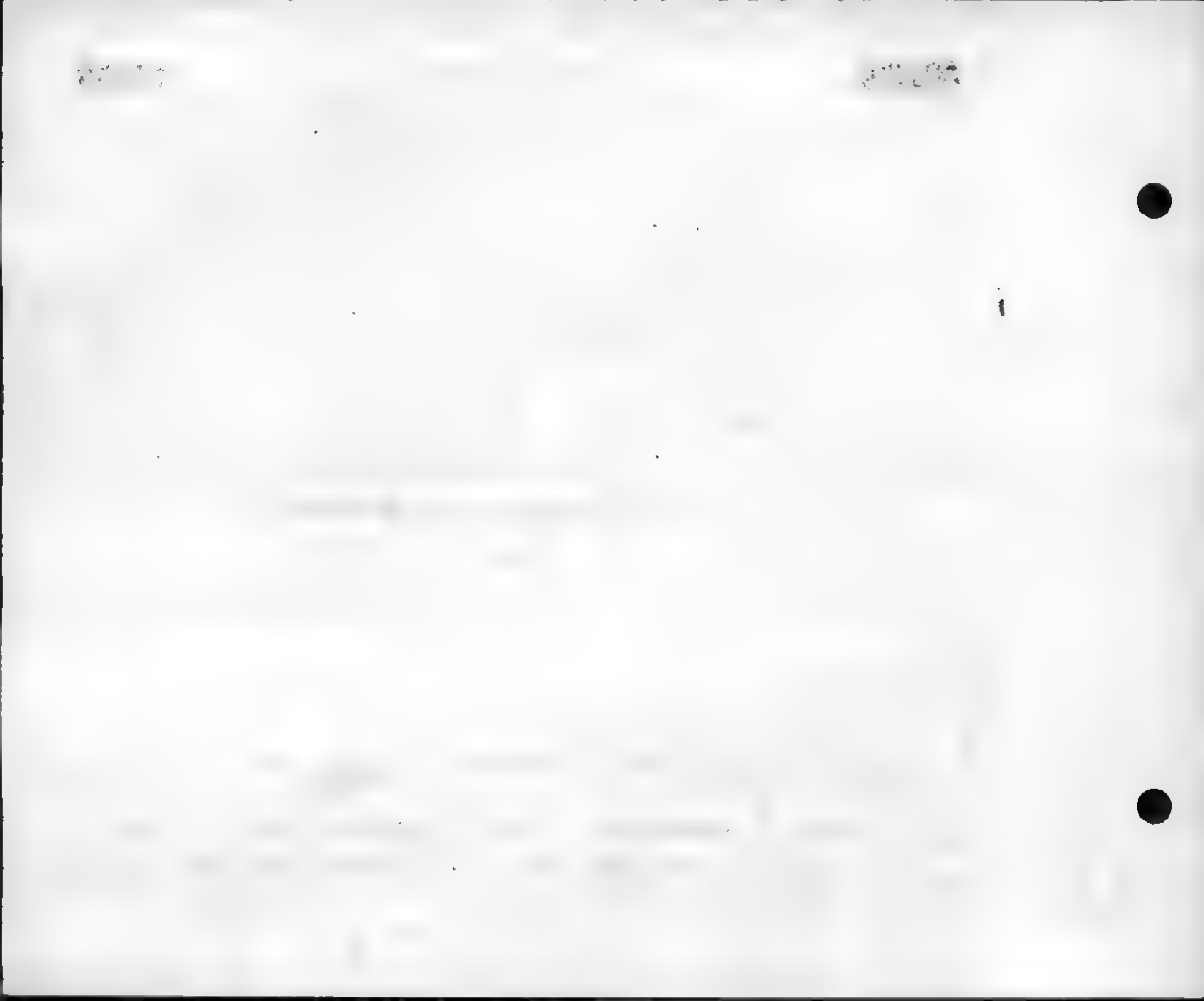
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15459

CERTIFICATE OF DEATH

15459

1 PLACE OF DEATH a COUNTY CARROLL MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution or Residence before admission) a STATE MARYLAND b COUNTY CARROLL	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c LENGTH OF STAY IN 1b NEW WINDSOR	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CARROLL CO GENERAL		d STREET ADDRESS CHURCH ST	
3 NAME OF DECEASED (Type or print) ETHEL MARGUERITE CRAWMER		4 DATE OF DEATH NOV 5 1966	
5 SEX F	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH MAR 19, 1898
9 AGE (In years lost birthday) 68		10 F UNDER 1 YEAR <input type="checkbox"/> 11 UNDER 24 HRS <input type="checkbox"/>	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) HOUSE WIFE		10b KIND OF BUSINESS OR INDUSTRY OWN HOME	
11 BIRTHPLACE (County & State or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME THOMAS T BROTHERS		14 MOTHER'S MAIDEN NAME EMMA STONE	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO. 29-20-0263	
17 INFORMANT HARRY CRAWMER		Address NEW WINDSOR MD	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 10 years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOT BY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home form factory, street office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from Nov 5, 1966 to Nov 5, 1966 , that (I) (we) last saw the deceased alive on Nov 5, 1966 , and that death occurred at 12:30 M, from causes and on the date stated above.			
22a SIGNATURE John S. Harshey		22b DATE SIGNED 11/5/66	
22c PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.		22d ADDRESS Church St. Westminster, Md.	
23a BURIAL, CREMATION REMOVAL (Specify) BURIAL	23b DATE THEREOF 11/8/66	23c NAME OF CEMETERY OR CREMATORY WINTERS	23d LOCATION (City or Town) (County) (State) NEW WINDSOR RURAL MD
24 FUNERAL DIRECTOR DD Hartzler & Sons		25a REC'D BY REGISTRAR NOV 9 1966	
25b REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15460

CERTIFICATE OF DEATH

15460

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if instit on: Residence before adm ssion) a. STATE Maryland b. COUNTY Fredeneb	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville, Md.		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) S S H Springfield State Hosp.		e. STREET ADDRESS Route #6	
3. NAME OF DECEASED (Type or print) Earl Nicholas Davis		4. DATE OF DEATH Month 11 Day 19 Year 1966	
5. SEX m	6. CO. OR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARR ED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE 3-19-1993
9. AGE (In years last b day) 73		10. IF UNDER 1 YEAR Months 11 Days 19 Hours 19 Min 66	
10a. USUAL OCCUPAT ON (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (Col. 1 & State, or foreign country) Fredrick, Co, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Davis		14. MOTHER'S MAIDEN NAME Alice Sewell	
15. WAS DECEASED EVER U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of serv. ce) Yes WW I		16. SOCIAL SECURITY NO 216-22-7938	
17. INFORMANT Alice Hill Rt 6		Address Fredrick, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Dissecting Aneurysm of entire Aorta DUE TO (c) 1 week			INTERVAL BETWEEN ONSET AND DEATH 1 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute brain syndrome associated with circulatory disorder			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) ---	
20c. TIME OF INJURY Month, Day Year Hour a.m. --- p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	20f. (City or town) (County) (State) ---
21. I certify that (I) (this hospital) attended the deceased from 11-9 , 19 66 , to 11-19 , 19 66 , that (a) (we) last saw the deceased alive on 11-19 , 19 66 , and that death occurred at 11P. M, from causes and on the date stated above.			
22a. SIGNATURE Sergio M. Palacio		22b. DATE SIGNED 11-19-99	
22c. PHYSICIAN'S NAME (Type) Sergio M. Palacio		22d. ADDRESS Sykesville, Maryland Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-23-66	23c. NAME OF CEMETERY OR CREMATORY Fairview	23d. LOCATION (City or Town) (County) (State) Fredrick Frederick, Md
24. FUNERAL DIRECTOR C.E. Hicks, 111 Frederick, Maryland		25a. REC'D BY REGISTRAR DATE NOV 23 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

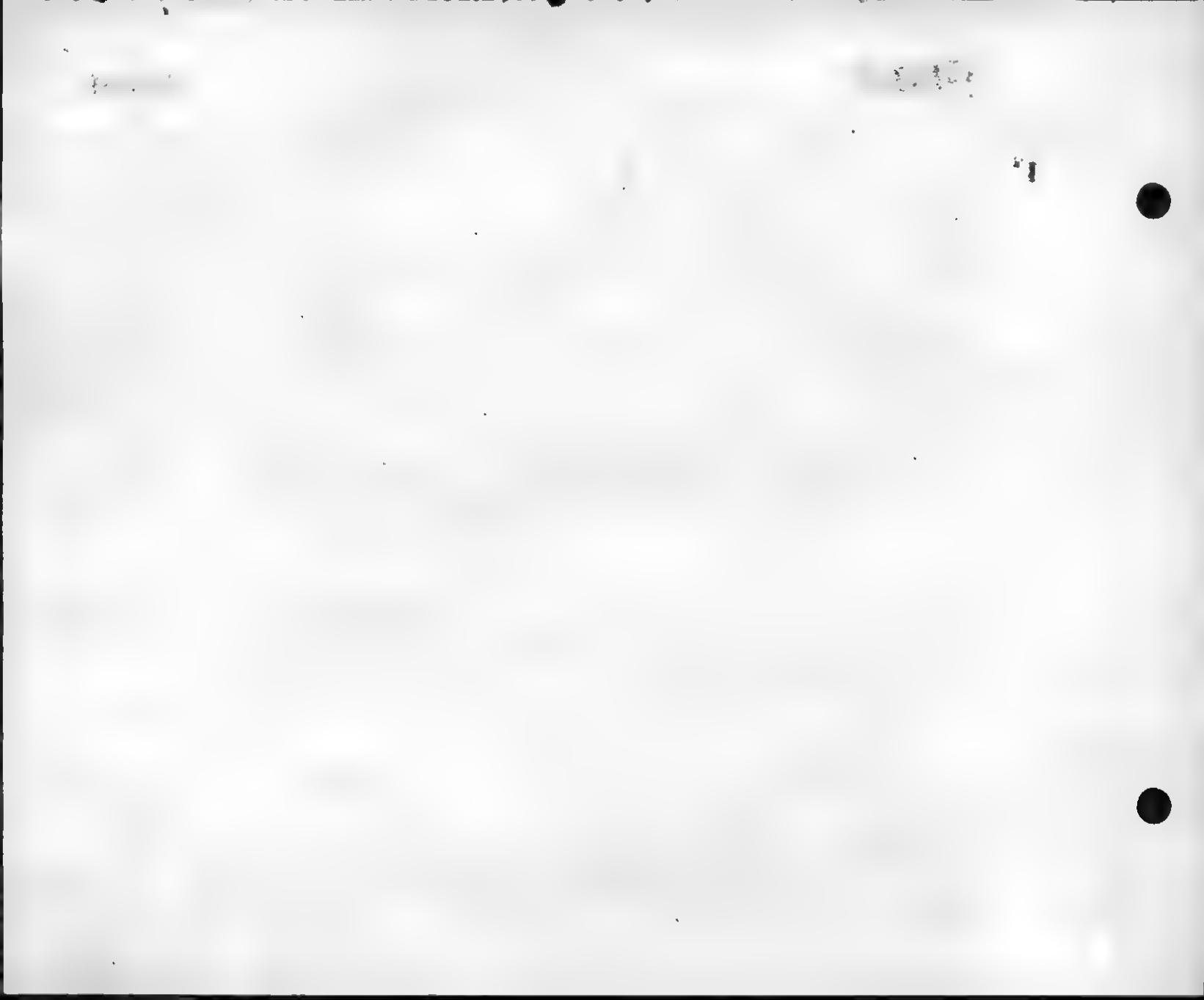
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15461

CERTIFICATE OF DEATH

15461

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> R2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO HOSPITAL</u>		d. STREET ADDRESS <u>UNION MILLS</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE EZRA DINTERMAN</u>		4. DATE OF DEATH Month Day Year <u>NOV 1 19 66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 16-1883</u> 83
9. AGE (In years last birthday) yrs		10. USUAL OCCUPATION (Give kind of work done during most of work life even if retired) <u>FARMER</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (County & State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>JACOB DINTERMAN</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN BOSTIAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>219-14-8822</u>	
17. INFORMANT <u>LETTIE DINTERMAN</u>		Address <u>R2 MD WESTMINSTER</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>2 X</u> DUE TO Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia; Chronic lymphocytic leukemia</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 28</u> , 19 <u>66</u> , to <u>Nov 1</u> , 19 <u>66</u> , that (I) (we) lost <u>Nov 1</u> , 19 <u>66</u> , and that death occurred at <u>4:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Harshey</u>		22b. DATE SIGNED <u>Nov 1, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>		22d. ADDRESS <u>8 Anchor St. Westminster, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>NOV 4-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MT HOPE</u>		23d. LOCATION (City or Town) (County) (State) <u>WOODSBORO MD</u>	
24. FUNERAL DIRECTOR <u>D D Hartzler & Sons, New Windsor</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 3 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

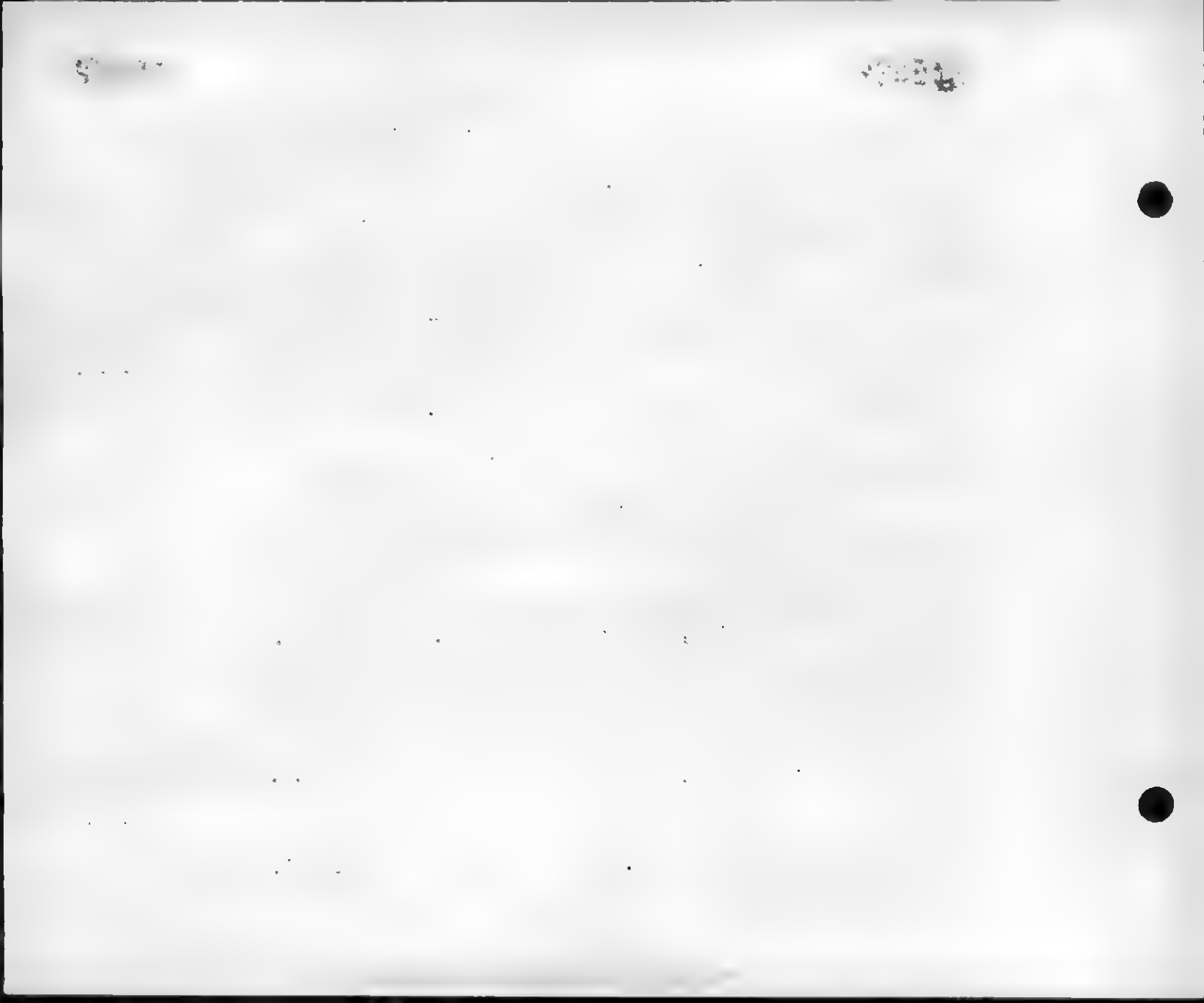
15462

CERTIFICATE OF DEATH

15462

1 PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b <u>10yrs. 6mos. 12dys.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				2 USUAL RESIDENCE (Where deceased lived, if instnat on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-New Windsor</u> d. STREET ADDRESS <u>R.D. 1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>BLANCHE</u> Middle <u>ETTA</u> Last <u>DODD</u>			4. DATE OF DEATH Month <u>November</u> Day <u>17</u> Year <u>19 66</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>5-25-92</u>		9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Quebec, Canada</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Garst</u>					
14. MOTHER'S MAIDEN NAME <u>Ella Rader</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					
16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Records, Springfield State Hospital</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>terminal</u> <u>years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Psychoneurotic reaction, depressive reaction. Septicemia.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>5-5-36</u> , to <u>11-17-66</u> 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>11-17-66</u> 19 <u> </u> , and that death occurred at <u>5:00</u> M, from causes and on the date stated above					
22a. SIGNATURE <u>Dr. Antonius Glahn, M.D.</u>		22b. DATE SIGNED <u>11-17-66</u>		22c. PHYSICIAN'S NAME (Type) <u>Antonius Glahn, M.D.</u>			
22d. ADDRESS <u>Springfield State Hospital</u> <u>Sykesville, Maryland 21784</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>11/19/1966 Pleasant Hill Cemetery Frederick Co., Md.</u>					
23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <u>J. M. Waltz, 241 Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>Nov 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15463

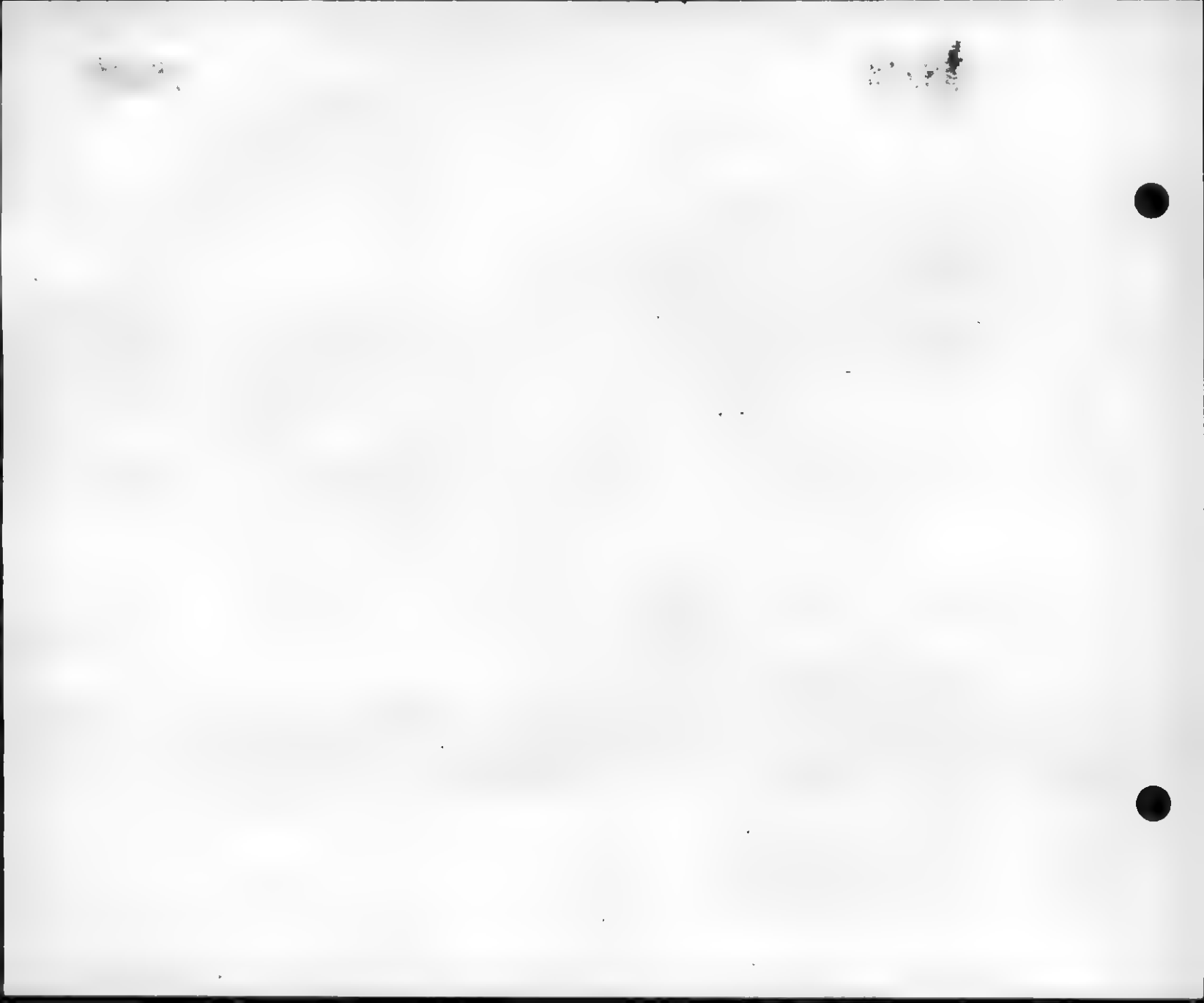
CERTIFICATE OF DEATH

15463

1 PLACE OF DEATH a COUNTY <u>Carroll</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>md</u> b COUNTY <u>Balto.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		c LENGTH OF STAY IN 1b <u>03</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Golden Age Home</u>		e STREET ADDRESS <u>1616 Hardwick Rd</u>	
3 NAME OF DECEASED (Type or print) <u>Agnes R Watson</u>		4 DATE OF DEATH Month <u>Nov.</u> Day <u>26</u> Year <u>1966</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept 29, 1890</u>
9 AGE (In years last birthday) <u>76</u> yrs		10 UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u> </u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u> </u>	
13 FATHER'S NAME <u>Philip Reese</u>		14 MOTHER'S MAIDEN NAME <u>America Matthews</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16 SOCIAL SECURITY NO. <u> </u>	
17 INFORMANT <u> </u>		Address <u> </u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY <u>443X</u> IMMEDIATE CAUSE (a) <u>Bronch. Pneumonia</u> DUE TO (b) <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>July 24, 1966</u> to <u>Nov 26, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov 26, 1966</u> , and that death occurred at <u>7 P</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>M N Martin</u>		22b DATE SIGNED <u>Nov 26-66</u>	
22c PHYSICIAN'S NAME (Type) <u>M N MARTIN</u>		22d ADDRESS <u>Westminster Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b DATE THEREOF <u>11-29-66</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Balto. Cem</u>		23d LOCATION (City or Town) (County) (State) <u>Balto. Md</u>	
24 FUNERAL DIRECTOR <u>J. H. H. H. 269 S. 4th St, Riviera Bld</u>		25a REC'D BY REGISTRAR DATE <u>DEC 1 1966</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the **both** certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

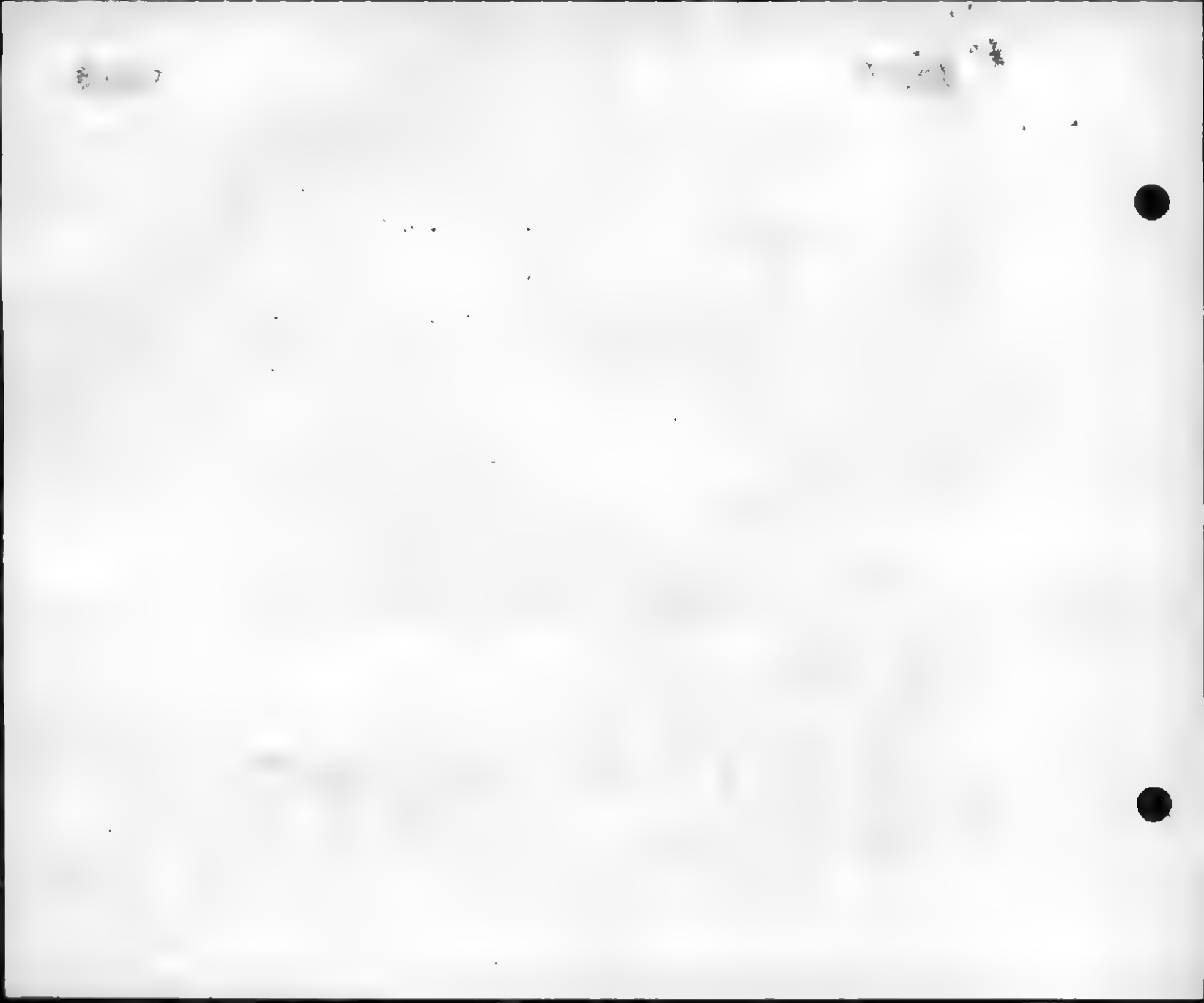
MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15464

CERTIFICATE OF DEATH

15464

1 PLACE OF DEATH a COUNTY <u>CARROLL CO.</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>CARROLL</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c LENGTH OF STAY in 1b <u>50 YRS.</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO. GENERAL HOSPT.</u>				d STREET ADDRESS <u>64 UNIONTOWN ROAD</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>ROSIE</u> Middle <u>-</u> Last <u>EBAUGH</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>26</u> Year <u>1966</u>			
5 SEX <u>F.</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>SEPT. 10, 1893</u>	9 AGE (In years lost birthday) <u>73</u> yrs	10 UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11 UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE-WIFE</u>		10b KIND OF BUSINESS OR INDUSTRY <u>-</u>		11 BIRTHPLACE (County & State, or foreign country) <u>CARROLL CO. MD</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.-9.</u>	
13 FATHER'S NAME <u>CHARLES H. WAGNER</u>				14 MOTHER'S MAIDEN NAME <u>MARY HAINES</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>-</u>		16 SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>SAME</u> <u>MR. JOHN B EBAUGH, ADDRESS</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Intestinal obstruction</u>							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 20</u> , 19 <u>66</u> , to <u>Nov 26</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov 26</u> , 19 <u>66</u> , and that death occurred at <u>6:30</u> M, from causes and on the date stated above.							
22a SIGNATURE <u>John S. Harshey</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/26/66</u>	
22c PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>				22d ADDRESS <u>8 Archer St. Westminster, Md.</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/29/66</u>		23c NAME OF CEMETERY OR CREMATORY <u>MEADOW BRANCH CEM. WESTMINSTER, MD.</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>J. E. Myers Jr. Westminster, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 29 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15465

15465

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester, Md</u> c. LENGTH OF STAY IN It <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Ingersoll Home for Homeless, 128 N. Main St</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u> d. STREET ADDRESS <u>3000 Bayview Park Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Annie</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 22, 1884</u> 9. AGE (In years last birthday) <u>82 yrs.</u> IF UNDER 1 YEAR Months <u>11</u> Days <u>9</u> IF UNDER 24 HRS. Hours <u>11</u> Min. <u>9</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Cephalo, Italy</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Imbroglio</u> 14. MOTHER'S MAIDEN NAME <u>Sarah Barranco</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, last, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>715-50-6367D4</u> 17. INFORMANT <u>Joseph Flannery (son)</u> Address <u>208 E. Broadway Baltimore, Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral - Arteriosclerosis</u> DUE TO (b) <u>Arteriosclerotic Cardio</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Vascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 yrs</u> <u>5 yrs</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18, OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)) 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>12/7</u> 20f. (City or town) <u>1965</u> (County) <u>11/9</u> (State) <u>1966</u>		21. I certify that (1) (this hospital) attended the deceased from <u>12/7</u> <u>1965</u> to <u>11/9</u> <u>1966</u> that (2) (we) last saw the deceased alive on <u>Nov 9</u> <u>1966</u> , and that death occurred at <u>1030</u> <u>PM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>W.H. Foard</u> 22b. DATE SIGNED <u>11/</u> 22c. PHYSICIAN'S NAME (Type) <u>W.H. Foard</u> 22d. ADDRESS <u>M.D. Manchester, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>INTERMENT</u> 23b. DATE THEREOF <u>NOV 13 1966</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>ULLRICH FUNERAL HOME</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE CEMETERY</u> 23d. LOCATION (City, town or county) <u>WOODLAWN MD</u> (State) <u>MD</u> 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>NOV 14 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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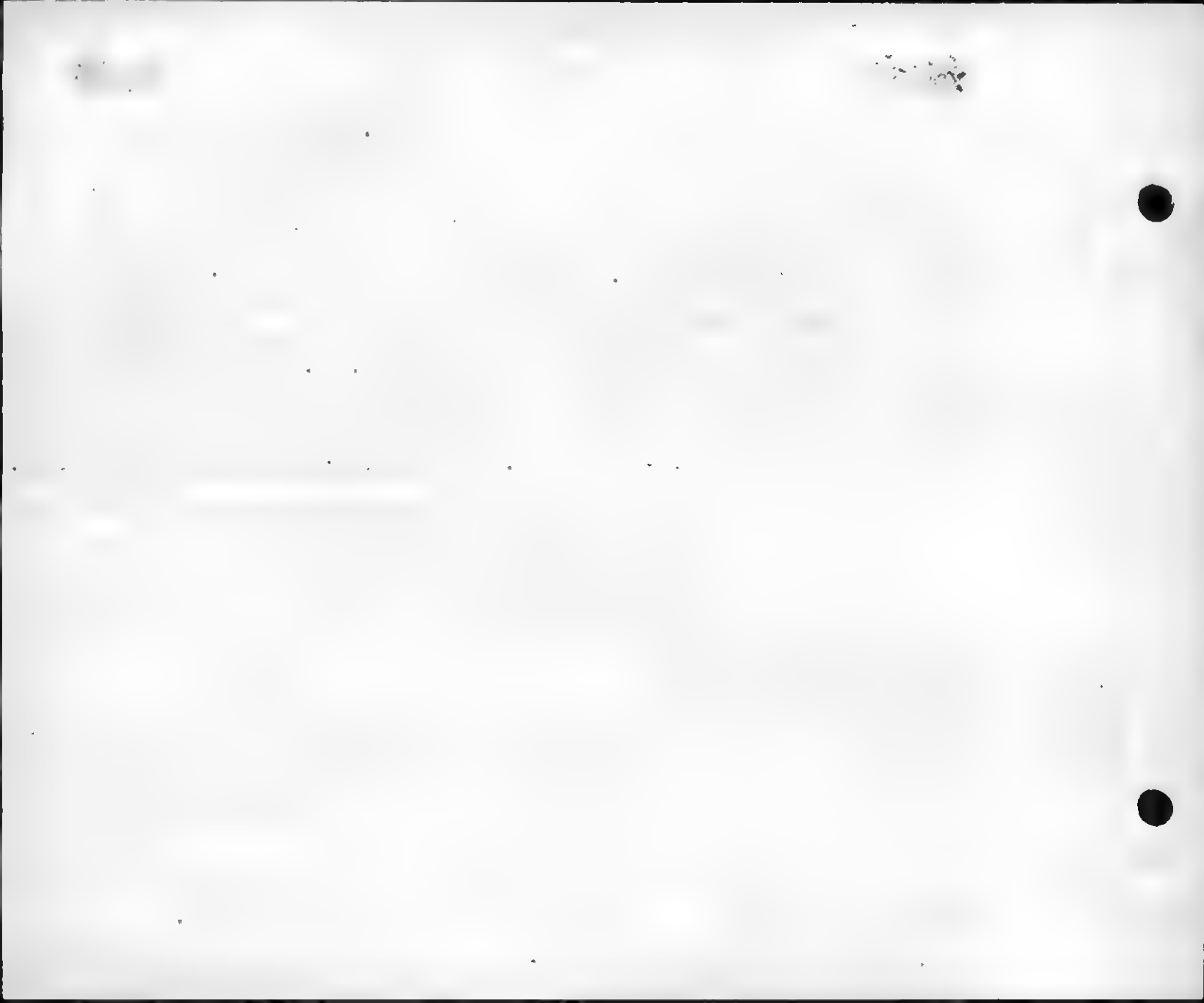
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15466

CERTIFICATE OF DEATH

15466

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Carroll	
c. LENGTH OF STAY IN Ia Finksburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cedarhurst Road		d. STREET ADDRESS Cecarhurst Road	
3. NAME OF DECEASED (Type or print) First James Middle E. Last Frebertshauser		4. DATE OF DEATH Month Nov. Day 6, Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1891
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer at Rosewood State Hospital		10b. KIND OF BUSINESS OR INDUSTRY Carroll Co. Md.	
11. BIRTHPLACE (County & State, or foreign country) Carroll Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Conrad Frebertshauser		14. MOTHER'S MAIDEN NAME Mary Tawney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-01-4927	
17. INFORMANT Mr. Clifford E. Frebertshauser		Address Finksburg, Md.	
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last arteriosclerosis (b) (c) 		INTERVAL BETWEEN ONSET AND DEATH 10 days years years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-1-1960 to 11-6-66 , that (I) was last saw the deceased alive on 11-5-1966 , and that death occurred at 5 A M, from causes and on the date stated above			
22a. SIGNATURE James G. Saffell		22b. DATE SIGNED 11-6-66	
22c. PHYSICIAN'S NAME (Type) James G. Saffell		22d. ADDRESS Reisterstown, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/9/66	23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Garden	23d. LOCATION (City or Town) (County) (State) Finksburg, Md.
24. FUNERAL DIRECTOR J. F. Eline & Sons		25a. REC'D BY REGISTRAR NOV 9 1966	
ADDRESS Reisterstown, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



15467

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15468

15468

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) York Street				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown d. STREET ADDRESS York Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Carel Middle Emanuel Last Frock			4 DATE OF DEATH Month November Day 23 Year 1966				
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 17, 1903		9 AGE (In years last birthday) 63 yrs 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		
10b KIND OF BUSINESS OR INDUSTRY Bakery Route		11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jesse W. Frock			14. MOTHER'S MAIDEN NAME Sarah Fink				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 218-32-1415	17. INFORMANT Mrs. Carel Frock				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Myocarditis & Myocardial Regeneration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, Deformed (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Grand Mal Epilepsy, Multiple Sclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from March 1962 to 11/23, 1966 that (I) (we) last saw the deceased alive on 11/15 1966 and that death occurred at 2 P.M. from causes and on the date stated above.							
22a. SIGNATURE R. S. McVaugh M.D.			22b. DATE SIGNED 11/23/66		22c. PHYSICIAN'S NAME (Type) R. S. McVaugh		
22d. ADDRESS Taneytown, Md.			23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial				
23b. DATE THEREOF Nov. 26, 1966		23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		23d. LOCATION (City or Town) (County) (State) Taneytown, Carroll, Maryland			
24. FUNERAL DIRECTOR John H. Skiles ADDRESS C.O. Fuss & Son, Taneytown, Md.			25a. REC'D BY REGISTRAR NOV 25 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page should be removed, and in any event, within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal.

200

200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

1

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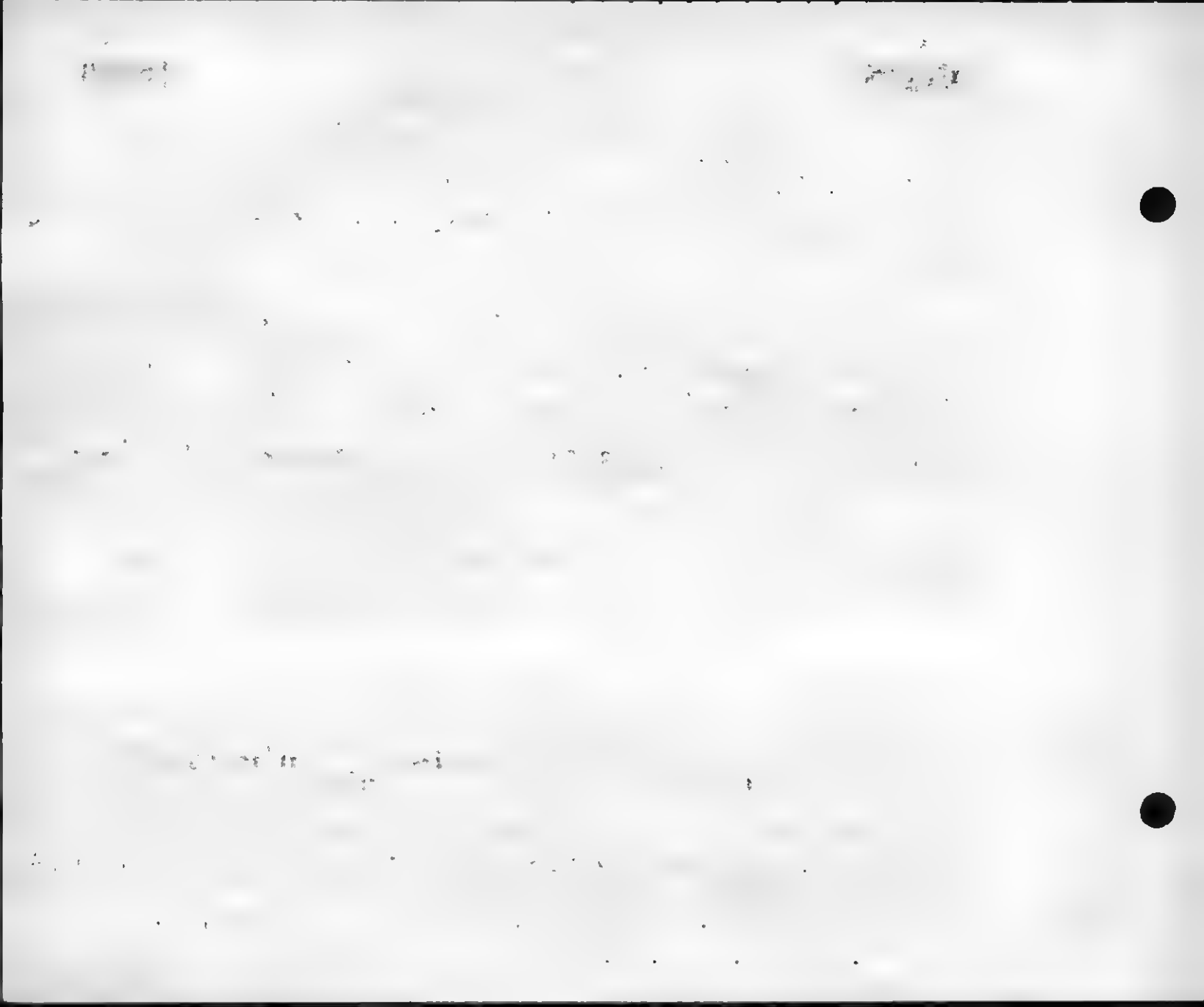
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15469

CERTIFICATE OF DEATH

15469

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Sykesville</u>				c. LENGTH OF STAY IN lb <u>12 months</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 21214</u>				d. STREET ADDRESS <u>4902 ARABIA AVE.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>George</u> Last <u>Fuchs</u>				4. DATE OF DEATH Month <u>11</u> Day <u>12</u> Year <u>1966</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-12-95</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>-</u> Hours <u>-</u> Min <u>-</u>		IF UNDER 24 HRS Hours <u>-</u> Min <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police man (Retired)</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Police</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>CONRAD FUCHS</u>				14. MOTHER'S MAIDEN NAME <u>ANNA K. PRELLER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>212-38-1592</u>		17. INFORMANT Address <u>Hospital Record S.S. Hosp.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute heart failure</u> DUE TO <u>antemortem generalized</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>antemortem generalized</u> DUE TO <u>antemortem generalized</u> (c) <u>antemortem generalized</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/10/66</u> , 19 <u>66</u> to <u>11/12/66</u> , that (I) (we) last saw the deceased alive on <u>10/12/66</u> , and that death occurred at <u>7:30</u> P.M., from causes and on the date stated above.							
22a. SIGNATURE <u>Sergio Palacio</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-12-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>SERGIO PALACIO</u>				22d. ADDRESS <u>SS Hosp Sykesville Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/16/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md. 21214</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

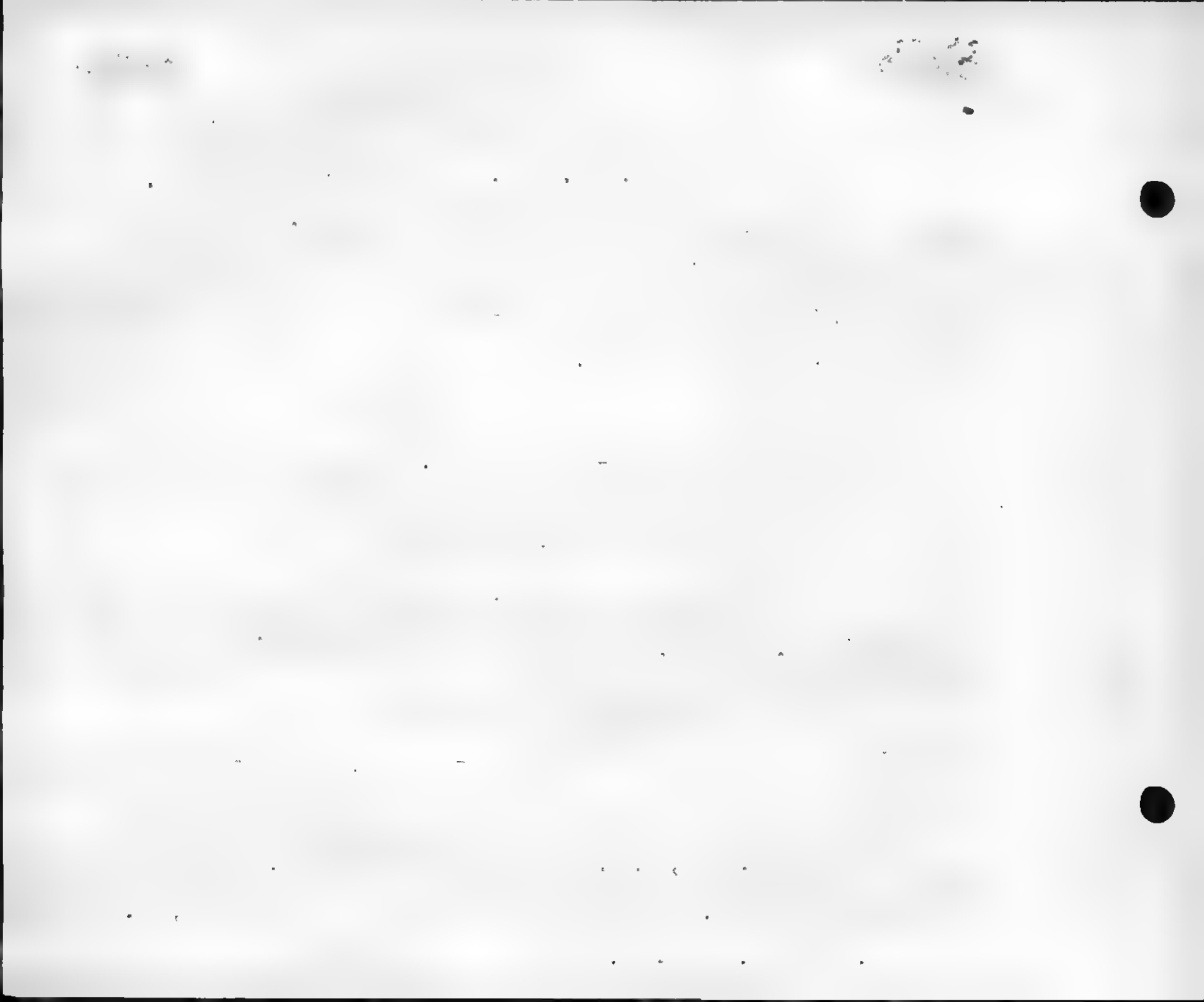
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15470

CERTIFICATE OF DEATH

15470

1 PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 6yrs. 2mos. 28dys.		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore #6		d. STREET ADDRESS 4206 Powell Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital													
3 NAME OF DECEASED (Type or print) (First Middle Last) (FILIPPO) PHILLIP (NMN) GASPARETTI						4 DATE OF DEATH Month Day Year NOVEMBER 16 19 66							
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 8-28-1888		9 AGE (In years last birthday) yrs 78		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer (Retired)				10b. KIND OF BUSINESS OR INDUSTRY Balto. City		11 BIRTHPLACE (County & State, or foreign country) Italy (First papers in 1913)				12. CITIZEN OF WHAT COUNTRY? Italy			
13 FATHER'S NAME Anthony Gasparetti						14. MOTHER'S MAIDEN NAME Theresa Camarni							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 212-16-8569A		17. INFORMANT Address Records, Springfield State Hospital							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Peripheral vascular disease DUE TO (c) Arterial occlusion, left leg												INTERVAL BETWEEN ONSET AND DEATH Days Years Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS with cerebral arteriosclerosis, with psychotic reaction. Late latent syphilis. Uremia.												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20x. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 8-18-60 , 19__, that (I) (we) last saw the deceased alive on 11-16-66 , 19__, and that death occurred at 3:15 p.m. 11-16-66 , 19__, from causes and on the date stated above.													
22a. SIGNATURE <i>Octavio A. Ruiz</i>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 11-16-66					
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D.						22d. ADDRESS Springfield State Hospital Sykesville, Maryland							
23a. BURIAL, CREMATION, REBURY (Specify) Burial				23b. DATE THEREOF 11/21/66.		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214						25a. REC'D BY REGISTRAR DATE NOV 18 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. If a please remove carbon papers and 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

154771

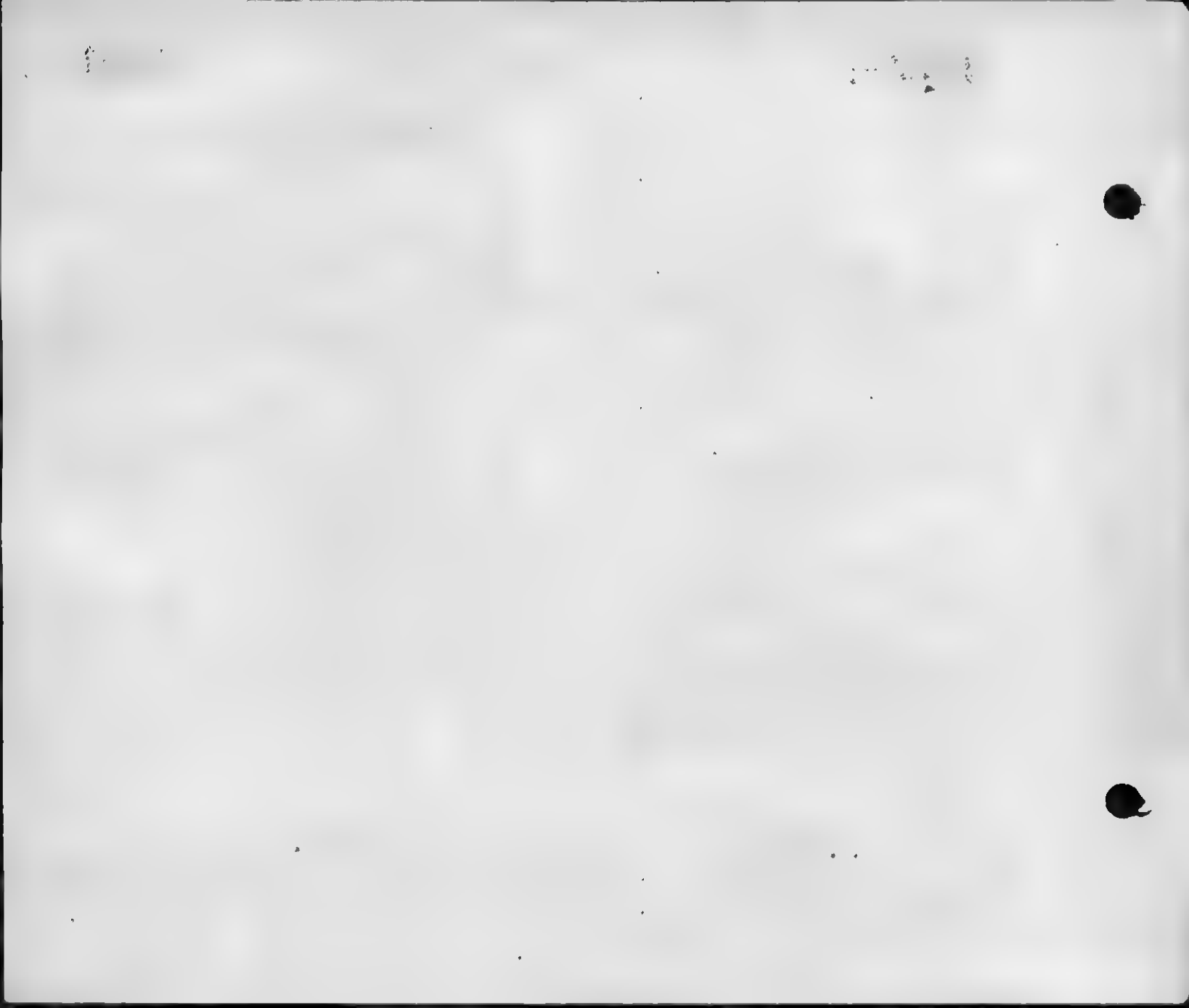
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

154771

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester, Md</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Longview Nursing Home 128 W. Main St</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Reisterstown Md.</u> d. STREET ADDRESS <u>Emory Rd</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Buelah</u> Middle <u>Pearl</u> Last <u>Green</u> 4. DATE OF DEATH Month <u>11</u> Day <u>19</u> Year <u>1966</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct 15 1888</u> 9. AGE (in years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (County & State, or foreign country) <u>near Emory church Carroll Co</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Frank Rorer</u> 14. MOTHER'S MAIDEN NAME <u>Elizabeth Mary Bond</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u> 16. SOCIAL SECURITY NO. <u>217-48-1672 (son)</u> 17. INFORMANT <u>Stirling Green - upper Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Arterio-sclerotic C.V. Disease</u> DUE TO (c) <u>8 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May 19 1966</u> to <u>May 19 1966</u> , that (I) (we) last saw the deceased alive on <u>May 19 1966</u> and that death occurred at <u>6:35 PM</u> from the causes and on the date stated above.		22a. SIGNATURE <u>M.C. Porterfield</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>11 20 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u>		22d. ADDRESS <u>Hampstead, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>11/22/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Emory Methodist Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Carroll Co. Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton-Eline</u> ADDRESS <u>Hampstead, Md.</u> 25a. REC'D BY REGISTRAR <u>Nov 23 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Young</u>	



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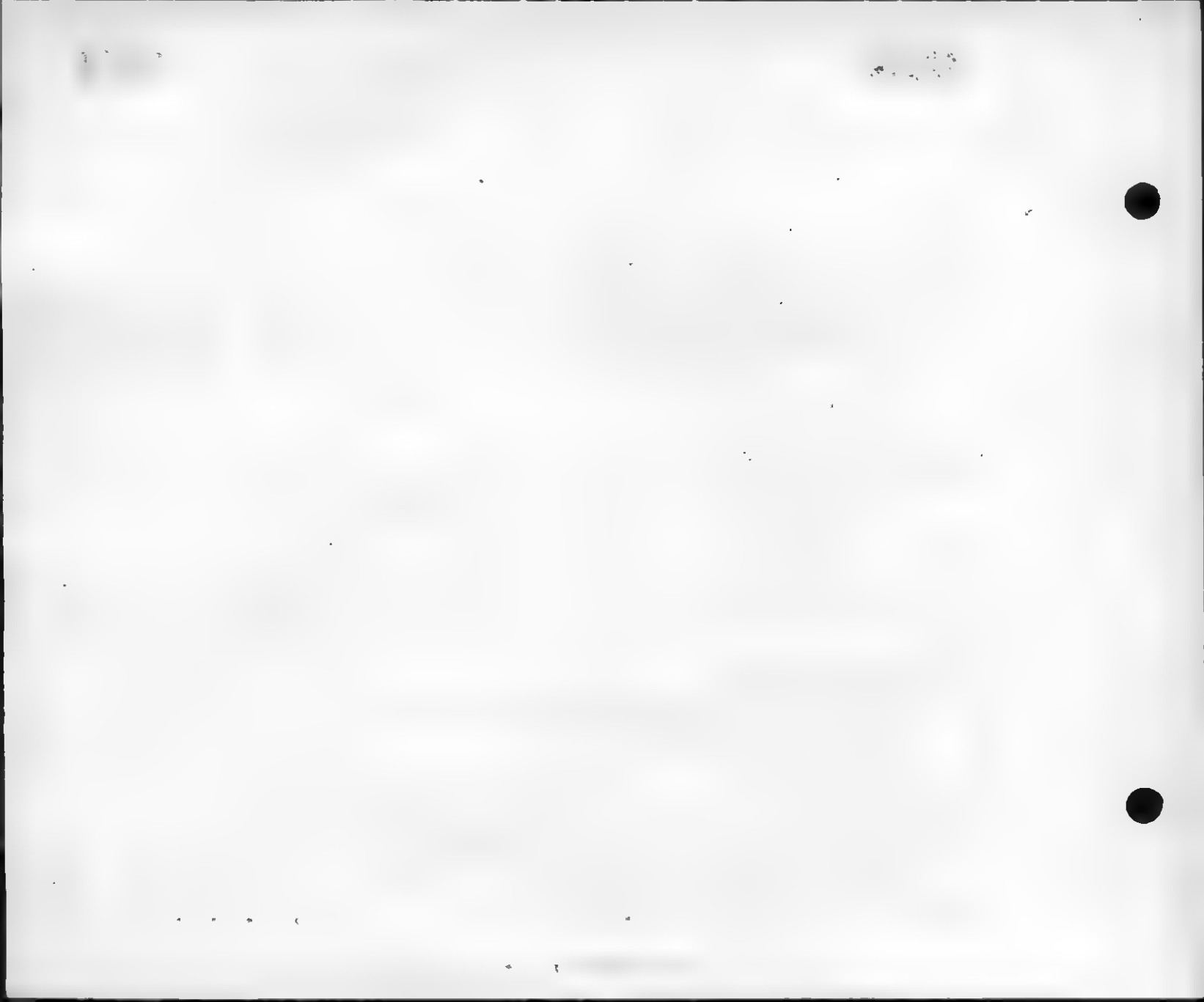
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
15472					15472						
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> c. LENGTH OF STAY IN 1b <u>154RS.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>52 GEORGE ST.</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> d. STREET ADDRESS <u>52 GEORGE ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>WALTER TURNER HAINES</u>			4. DATE OF DEATH Month <u>NOV.</u> Day <u>12</u> Year <u>1966</u>								
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 16, 1895</u>		9. AGE (In years last birthday) <u>71</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OPERATOR, CLEANING & PRESSING EST.</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>CARROLL CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JACOB A. HAINES</u>				14. MOTHER'S MAIDEN NAME <u>ELLA M. SINGER</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>				16. SOCIAL SECURITY NO. <u>219-14-8984</u>		17. INFORMANT <u>MRS WALTER T. HAINES, SR.</u> Address <u>SAME ADDRESS</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of the lungs</u> DUE TO (b) <u>(Operation at University Hosp for Ca 7-66)</u> DUE TO (c) <u>Carcinoma of lung</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. <u>Cigarette smoking</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>about 3 mo</u> <u>6 mo</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May 17, 1966</u> , to <u>Nov. 12, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov. 12, 1966</u> , and that death occurred at <u>2:15</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>C. L. Billingslea</u> M.D.						22b. DATE SIGNED <u>11-14-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>C. L. Billingslea</u>						22d. ADDRESS <u>Westminster, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/15/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PLEASANT VALLEY CEM.</u>		23d. LOCATION (City, town or county) (State) <u>RURAL, WESTMINSTER, MD.</u>					
24. FUNERAL DIRECTOR <u>J. E. Myron, Jr., WESTMINSTER, MD.</u>						25a. REC'D BY REGISTRAR <u> </u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15474					15474				
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY				
CARROLL MARYLAND					MARYLAND CARROLL				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
RURAL WESTMINSTER			6 YEARS		WESTMINSTER				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ROUTE #2 WESTMINSTER					ROUTE #2				
3. NAME OF DECEASED (Type or print)			First Middle Last		4. DATE OF DEATH		Month Day Year		
WILLIAM - HANS BOROUGH					NOV.		15		1966
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	MAR 29 1888		78 yrs.		Months Days		Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
MACHINE OPER.			CONSTRUCTION		PALASTINE TEXAS		UNITED STATE		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Unknown					Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT				
YES			WORLD WARI, 205-10-224/4		MRS WILLIAM HANS BOROUGH ROUTE #2 WESTMINSTER				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4 DAYS DUE TO MYOCARDIAL INFARCTION DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 10 YEARS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
Hour a.m. p.m. 19			While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						
21. I certify that (I) (this hospital) attended the deceased from SEPT 1962 to NOV 15 1966 that (I) (we) last saw the deceased alive on NOV 15 1966 and that death occurred at 10:55 AM, from the causes and on the date stated above.									
22a. SIGNATURE					22b. DATE SIGNED				
Daniel I Welliver					11-15-66				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
DANIEL I WELLIVER					19 RIDGE RD WESTMINSTER				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
Burial			11/18/66		Mt. Zion Cemetery		York, Pa. R. D. 7		
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE				
Richard A. Little					DATE NOV 17 1966 J. Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

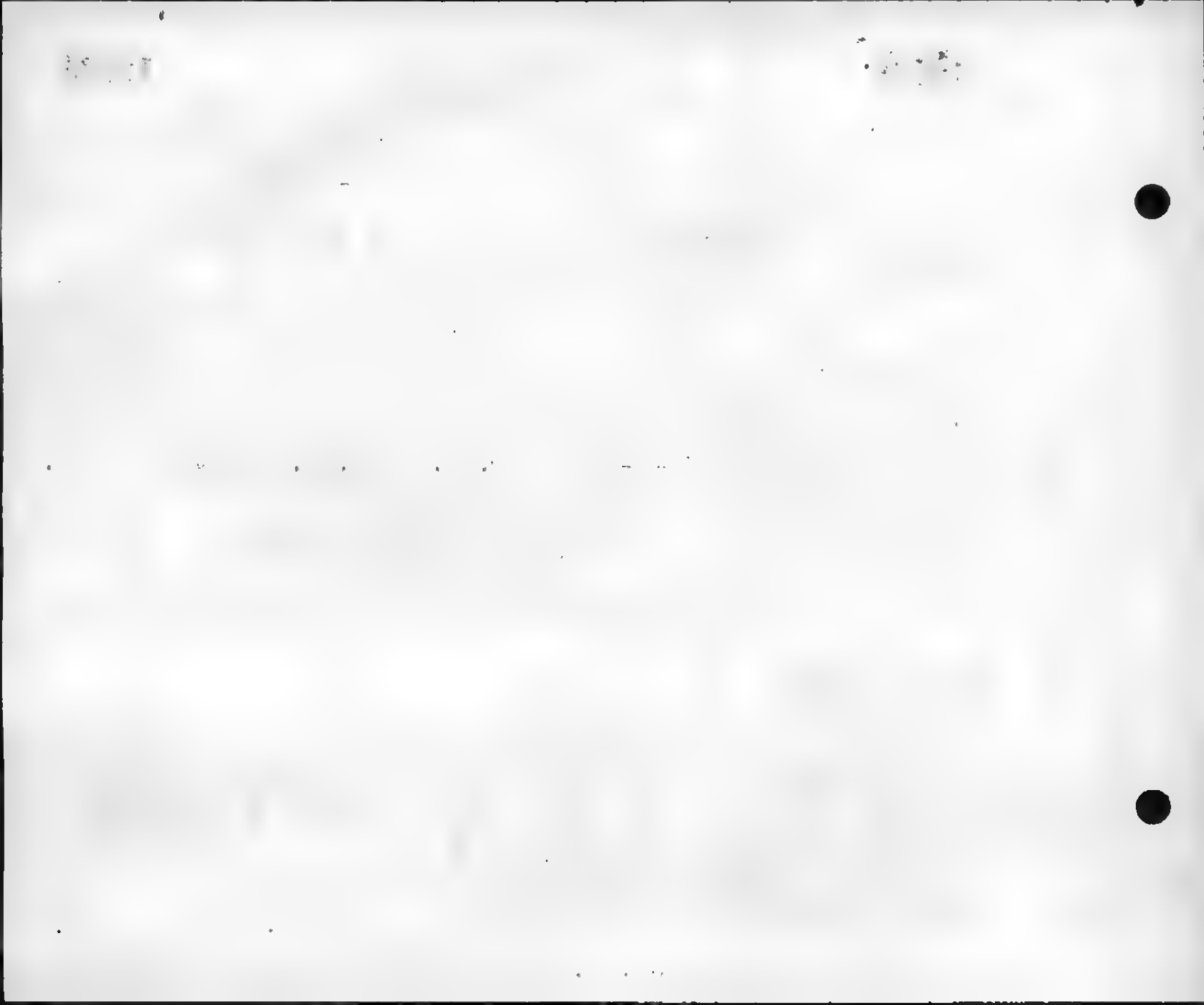
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15475

CERTIFICATE OF DEATH

15475

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if not tut on Residence before adm ssion) a. STATE Maryland b. COUNTY Carroll	
b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-Hampstead		c CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Hampstead	
d NAME OF HOSPITAL OR INST TUTION (if not in hospital, give street address) Upper Beckleysville Road		d STREET ADDRESS Upper Beckleysville Road	
3. NAME OF DECEASED (Type or print) First GEORGE Middle HARMON Last HARMON		4. DATE OF DEATH Month 11 Day 29 Year 1966	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF B RTH 11/3/03
9 AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 63 Days 63 Hours 63 Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b KIND OF BUSINESS OR INDUSTRY Maryland	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME G. Glenville Harmon		14 MOTHER'S MAIDEN NAME Florence Harmon	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO. 219-01-3402	
17. INFORMANT Mr. Wm. Harmon, Jr.		Address Hampstead RD 2, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subm Mary edema DUE TO Conjunctive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1WK (c) 1WK		INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) Hemophysis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 11/27 , 19 66 , to 11/28 , 19 66 , that (1) (we) lost say the deceased alive on 11/28 , 19 66 , and that death occurred at 5 A M, from causes and on the date stated above.			
22a SIGNATURE: D. A. Tipton		22b. DATE SIGNED 11/29/66	
22c. PHYSICIAN'S NAME (Type) D. A. Tipton M.D.		22d ADDRESS Greenmont, Md	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 12/1/66	23c NAME OF CEMETERY OR CREMATORY Grave Run Cemetery	23d LOCATION (City or Town) (County) (State) Balto. Co Md.
24. FUNERAL DIRECTOR Tipton-Eline		25a. REC'D BY REGISTRAR DEC 2 1966	
ADDRESS Hampstead, Md.		25b REGISTRAR'S SIGNATURE Charles Judge	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

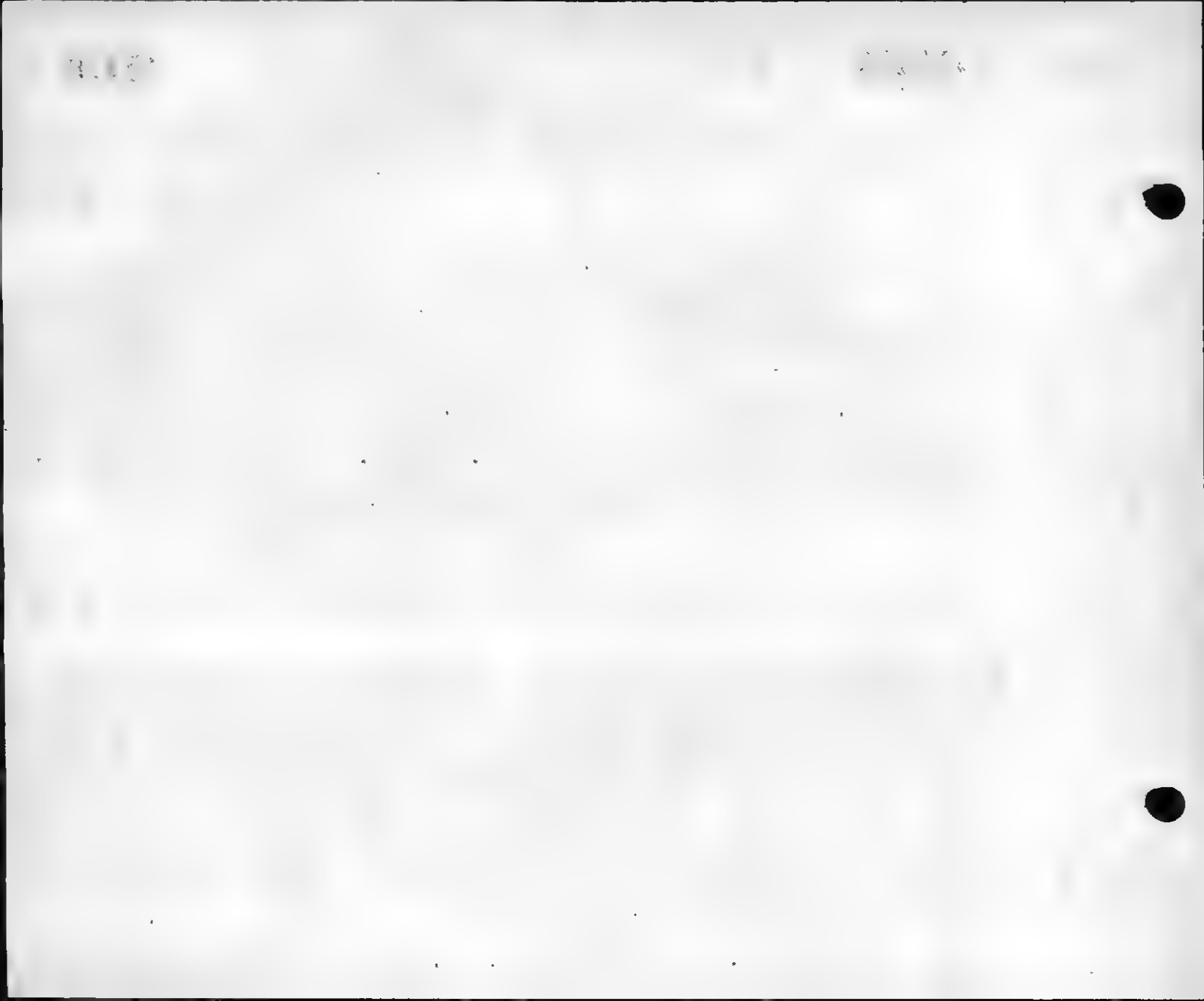
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
35D0 4-64

15476
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
15476

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Hampstead c. LENGTH OF STAY IN 1b 11 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shiloh Road		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Hampstead d. STREET ADDRESS Shiloh Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FORREST F. HARRIS		4. DATE OF DEATH Month 11 Day 15 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/2/1909
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 11 Days 15 Hours 16 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James G. Harris		14. MOTHER'S MAIDEN NAME W. Alice Frank	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW2		16. SOCIAL SECURITY NO. 220-07-8975	
17. INFORMANT Mrs. Mary R. Harris, Hampstead, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis (with) Suicide 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED 11-15-66 135 W. Preston Street, Baltimore 1, Md. 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 11/18/66 23c. NAME OF CEMETERY OR CREMATORY Hampstead Cemetery 23d. LOCATION (City, town or county) (State) Hampstead, Md. 24. FUNERAL DIRECTOR Tipton-Eline Fun. Home, Hampstead, Md. 25a. REC'D BY REGISTRAR NOV 21 1966 25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15477

15477

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONT. CO. CAP.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN 1b 1 day	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CARROLL CO. GEN. HOSPITAL		d. STREET ADDRESS 5350 QUINCY ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NELL Middle BELL Last JOHNSTON		4. DATE OF DEATH Month NOV. Day 20 Year 1966	
5. SEX F.	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 3, 1880
9. AGE (In years lost birthday) 85 yrs		F UNDER 1 YEAR Months Days Hours Min	
10a. SOCIAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MURRAY IOWA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT EVANS		14. MOTHER'S MAIDEN NAME MARY ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 219-54-9041	
17. INFORMANT FRANCIS T. JOHNSTON		Address 12 HERBERT DRIVE, ELLICOTT CITY MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Inter-vascular Heart Disease +266 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov 20, 1966 , to Nov 20, 1966 , that (I) (we) last saw the deceased alive on Nov 20, 1966 , and that death occurred at 4:25 PM , from causes and on the date stated above.			
22a. SIGNATURE John S. Harshey		22b. DATE SIGNED 11/20/66	
22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.		22d. ADDRESS 8 Anchor St. Westminster, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE THEREOF 11/25/66	23c. NAME OF CEMETERY OR CREMATORY RANDOLPH CEMETERY	23d. LOCATION (City or Town) (County) (State) RANDOLPH, IOWA
24. FUNERAL DIRECTOR J. S. Myers, Jr. Westminster, Md		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE		DATE NOV 23 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

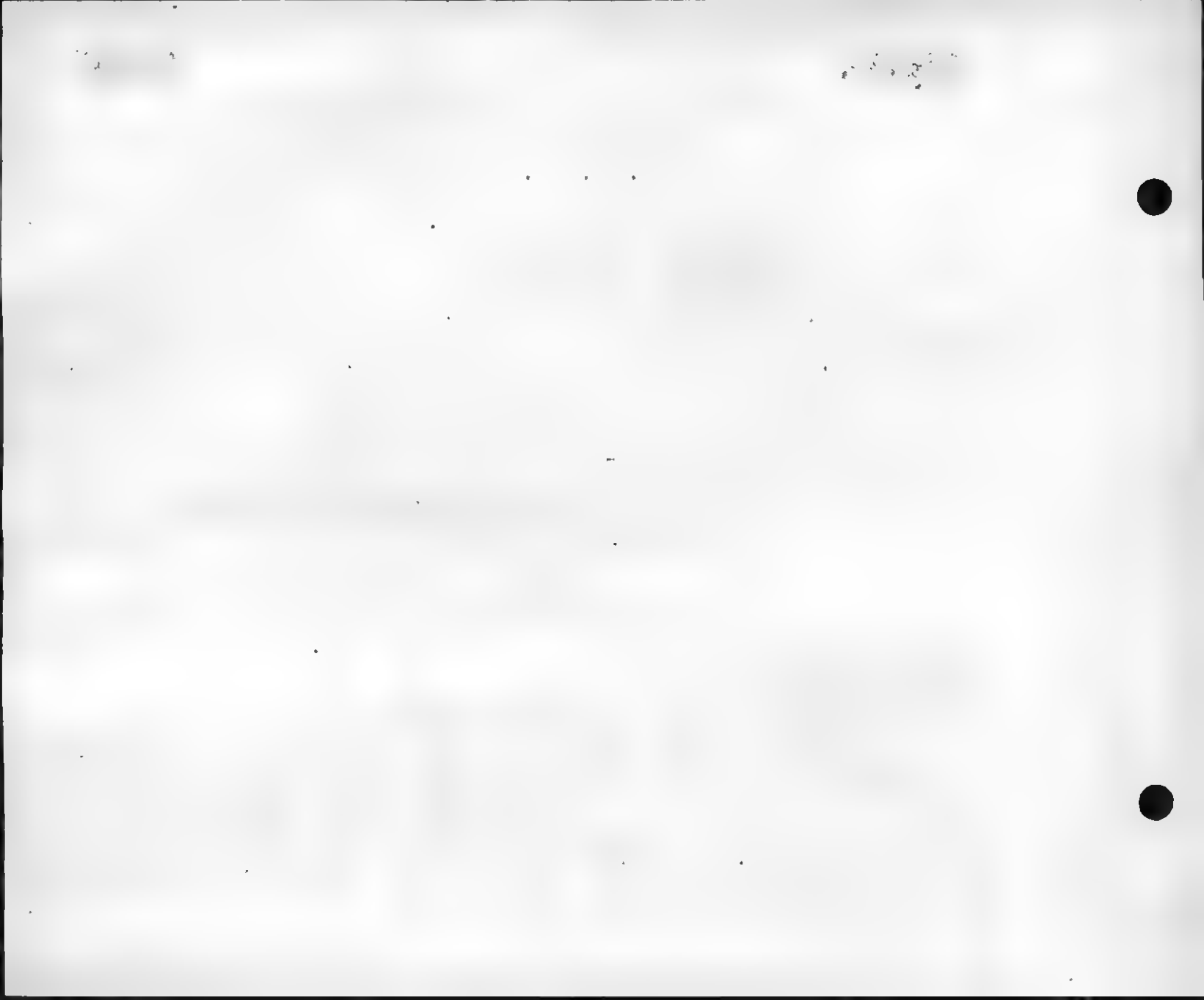
15478

CERTIFICATE OF DEATH

15478

1 PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural--Sykesville</u> c. LENGTH OF STAY IN 1b <u>9y. 7m. 18d.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>5 E. 33rd Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3 NAME OF DECEASED (Type or print) First Middle Last <u>Genevieve Tilden Kennard</u>				4 DATE OF DEATH Month Day Year <u>11 23 19 66</u>											
5 SEX <u>female</u>		6 COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>2/3/87</u>		9 AGE (In years last birthday) yrs <u>79</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY _____				11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12 CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Edward Kennard</u>						14. MOTHER'S MAIDEN NAME <u>Sparks, Emma</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16 SOCIAL SECURITY NO <u>220-30-5899</u>				17 INFORMANT Address <u>Springfield State Hospital records, Sykesville</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction with perforation of the left ventricle muscle</u> DUE TO <u>Coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenic reaction, chronic undifferentiated type.</u>												INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Years</u>			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)											
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)							
21. I certify that (this hospital) attended the deceased from <u>4/5/1957</u> to <u>11/23/1966</u> , that (we) last saw the deceased alive on <u>11/23/1966</u> , and that death occurred at <u>11:17</u> M, from causes and on the date stated above.															
22a. SIGNATURE <u>Carlos G. Lavin</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>11/23/66</u>							
22c. PHYSICIAN'S NAME (Type) <u>Carlos G. Lavin, M. D.</u>						22d. ADDRESS <u>Springfield State Hospital Sykesville, Maryland</u>									
23a BURIAL, CREMATION, REMAINS (Specify) <u>BURIED</u>				23b DATE THEREOF <u>11-26-1966</u>		23c NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>				23d LOCATION (City or Town) (County) (State) <u>Chestertown, Maryland</u>					
24 FUNERAL DIRECTOR <u>Wm. Cook-Brooks, Inc.</u>						ADDRESS <u>1217 St. Paul St. Baltimore 2, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 28 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15479

CERTIFICATE OF DEATH

15479

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville c. LENGTH OF STAY IN 1b 32y 6m 26d d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Rfd. 1 d. STREET ADDRESS Downsville e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Franklin Last Kepler		4. DATE OF DEATH Month 11 Day 15 Year 19 66	
5. SEX M	6. CO. OR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-3-00
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Kepler		14. MOTHER'S MAIDEN NAME Glenmie M. Brandenburg	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 219-54-0758	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia DUE TO (b) Perforated duodenal ulcer DUE TO (c) Chronic brain syndrome associated with intracranial infection other than Syphilis, Epidemic encephalitis with psychotic reaction			INTERVAL BETWEEN ONSET AND DEATH Days Day
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with intracranial infection other than Syphilis, Epidemic encephalitis with psychotic reaction			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) --		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour a.m. --- p.m. --- 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from 4-19 , 19 38 , to 11-15 , 19 66 , that (b) (we) last saw the deceased alive on 11-15 , 19 66 , and that death occurred at 9:45 M, from causes and on the date stated above.			
22a. SIGNATURE Heinz H. Klea...		22b. DATE SIGNED 11-15-66	
22c. PHYSICIAN'S NAME (Type) Springfield State Hospital		22d. ADDRESS Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) B	23b. DATE THEREOF 11-18-66	23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery	23d. LOCATION (City or Town) (County) (State) Boonsboro, Md.
24. FUNERAL DIRECTOR John H. Bast, Jr.		25a. REC'D BY REGISTRAR NOV 18 1966	
25b. REGISTRAR'S SIGNATURE John H. Bast, Jr.		25c. ADDRESS 112 N. MAIN STREET, BOONSBORO, MD.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1911

1911



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

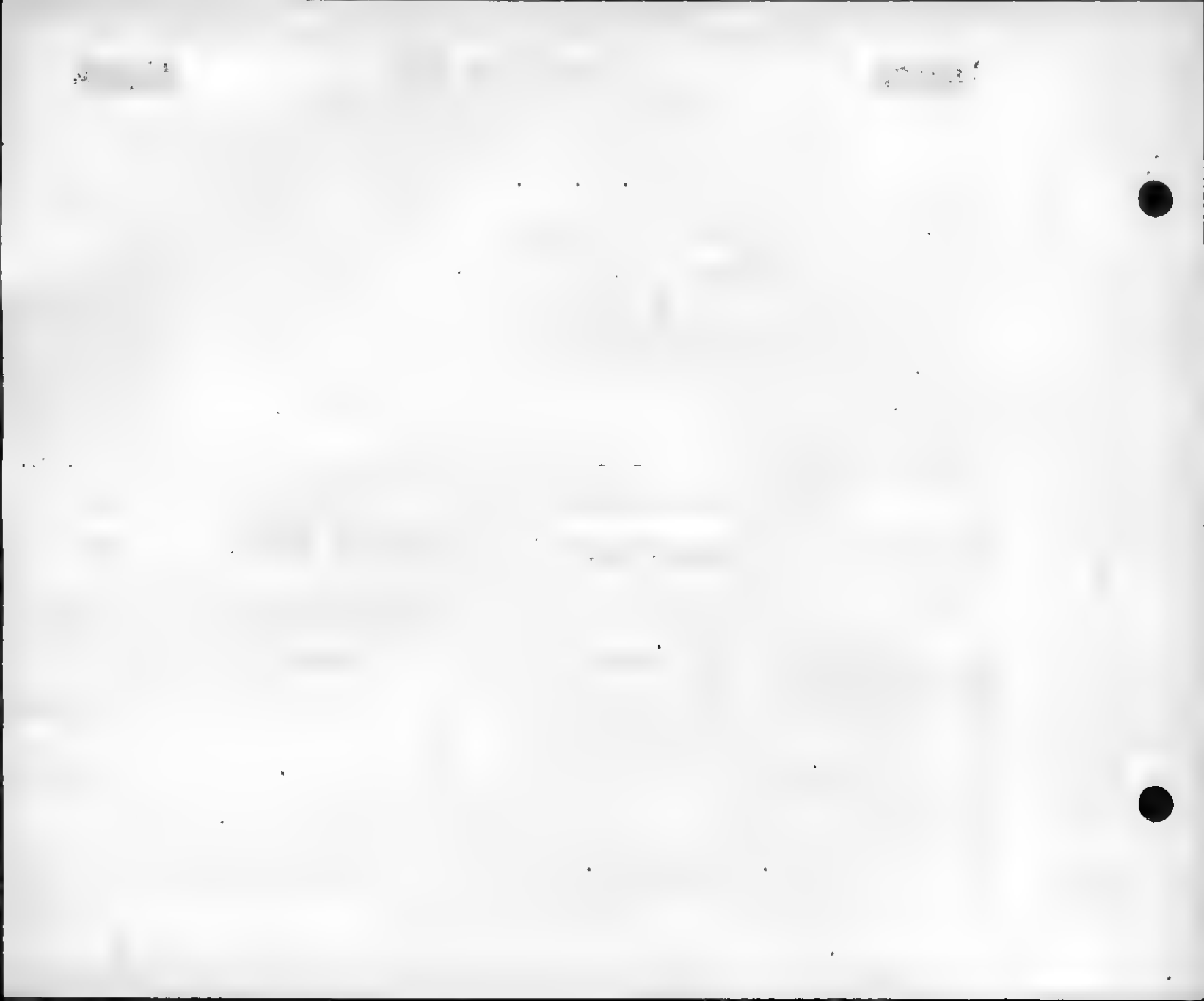
CERTIFICATE OF DEATH

15480

15480

1 PLACE OF DEATH a COUNTY Carroll MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a STATE Maryland b COUNTY Allegany			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville			c LENGTH OF STAY IN 1b 19y. 9m. 13d.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d STREET ADDRESS 44 Marion Street		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Annabelle - Lane				4 DATE OF DEATH Month Day Year 11 3 1966			
5 SEX female	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/29/98		9 AGE (In years last birthday) 68 y/s	IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Evans				14. MOTHER'S MAIDEN NAME Emma Lancaster			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 214-07-1938		17. INFORMANT Address Springfield Hospital records, Sykesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Old myocardial infarct and severe coronary arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH weeks years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Depressive reaction.						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that the (this hospital) attended the deceased from 1/20/1947 to 11/3/1966 , that it (we) last saw the deceased alive on 11/3/1966 , and that death occurred at 9:45 P.M. from causes and on the date stated above.							
22a SIGNATURE <i>Naci N. Buyukunsal</i> M.D.			ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 11/4/66		
22c PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M.D.			22d. ADDRESS Springfield State Hospital Sykesville, Maryland				
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 11/6/66	23c NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany, Maryland			
24 FUNERAL DIRECTOR H. Lee Silcox <i>Silcox Funeral Home Cumberland</i>			ADDRESS Maryland		25a REC'D BY REGISTRAR DATE NOV 7 1966	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15481

CERTIFICATE OF DEATH

15481

1 PLACE OF DEATH a COUNTY <u>CARROLL</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c LENGTH OF STAY IN b <u>56 YRS</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		d IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO. GENERAL HOSP</u>				d STREET ADDRESS <u>162 WILLIS ST.</u>			
3 NAME OF DECEASED (Type or print) <u>JAMES GLOYD LEAHY</u> <small>First Middle Last</small>				4 DATE OF DEATH <u>NOV. 7 1966</u> <small>Month Day Year</small>			
5 SEX <u>M.</u>		6 COLOR OR RACE <u>W.</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>JUNE 5, 1910</u>	
9 AGE (In years last birthday) <u>56</u>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b KIND OF BUSINESS OR INDUSTRY <u>INDUSTRIAL</u>		11 BIRTHPLACE (County & State, or foreign country) <u>WESTMINSTER, MD.</u>	
13 FATHER'S NAME <u>JAMES G. LEAHY</u>				14 MOTHER'S MAIDEN NAME <u>MAMIE V. BARBER</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16 SOCIAL SECURITY NO <u>185-01-2890</u>		17 INFORMANT Address <u>SAME</u> <u>MRS KATHYLYN MELLOR LEAHY</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhagic pancreatitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 5</u> , 19 <u>66</u> , to <u>Nov 7</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov 7</u> , 19 <u>66</u> , and that death occurred at <u>5:30</u> M, from causes and on the date stated above.							
22a SIGNATURE <u>John S. Harshey</u>				22b. DATE SIGNED <u>11/7/66</u>		22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>	
22d. ADDRESS <u>Windsor St. Westminster, Md</u>							
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>11/10/66</u>		23c NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>		23d LOCATION (City or Town) (County) (State) <u>WESTMINSTER MD.</u>	
24 FUNERAL DIRECTOR <u>J. E. Myers, Jr., WESTMINSTER, MD.</u>				25a REC'D BY REGISTRAR DATE <u>NOV 10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

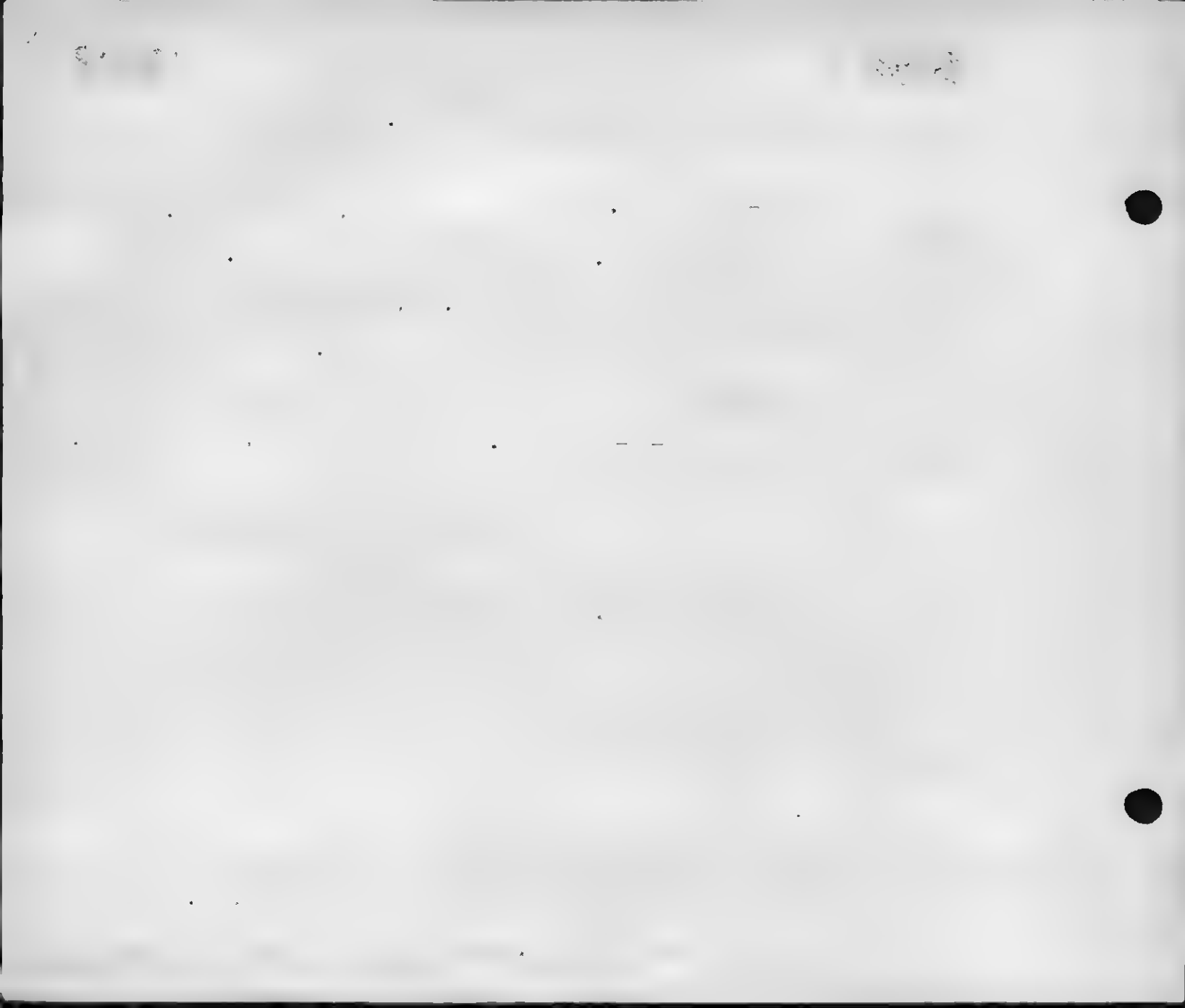
CERTIFICATE OF DEATH

15482

15482

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville,		c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md.		b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 3011 W. Belvedere Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William		First William		Middle H.		Last Lycett		4. DATE OF DEATH Nov. 2 1966		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH Aug. 12, 1879		9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Timekeeper		10b. KIND OF BUSINESS OR INDUSTRY Steel Foundry		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME Michael Lycett		14. MOTHER'S MAIDEN NAME Ann Rebeca O'Neill		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-10-9506		17. INFORMANT Mrs. Rose Lycett, 3011 W. Belvedere Ave.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremic Coma DUE TO (b) Generalized Arteriosclerotic C.V.D DUE TO (c) Nephrosclerosis; Anasarca PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Basal Cell Carcinoma of Skin		INTERVAL BETWEEN ONSET AND DEATH 48 hours 12 yrs. 3 yrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Oct 15, 1966 to Nov 2, 1966 , that (I) (we) last saw the deceased alive on Oct 31, 1966 , and that death occurred at 5:15 PM , from the causes and on the date stated above.		22a. SIGNATURE Sani Okutman M.D.		22b. DATE SIGNED Nov 2, 1966	
22c. PHYSICIAN'S NAME (Type) Sani Okutman		22d. ADDRESS Sykesville, Md		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/5/66		23c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Md.		24. FUNERAL DIRECTOR'S SIGNATURE Vernon Lemmon		25a. REC'D BY REGISTRAR NOV 4 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Item 1d 11/15/66

CERTIFICATE OF DEATH

Reg. Dist. No.

15483

15483

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>206 York St.</u>		d. STREET ADDRESS <u>206 York St</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Edward</u> Middle <u>Markel</u> Last		4. DATE OF DEATH <u>Nov</u> Month <u>5</u> Day <u>1966</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25, 1878</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13. FATHER'S NAME <u>Elias Markel</u>		14. MOTHER'S MAIDEN NAME <u>Mary Rinehart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-01-67584</u>	
17. INFORMANT <u>Miss Anna Catherine</u> Address <u>Manchester, Md</u>			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) <u>Diarrhea</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 yrs</u>
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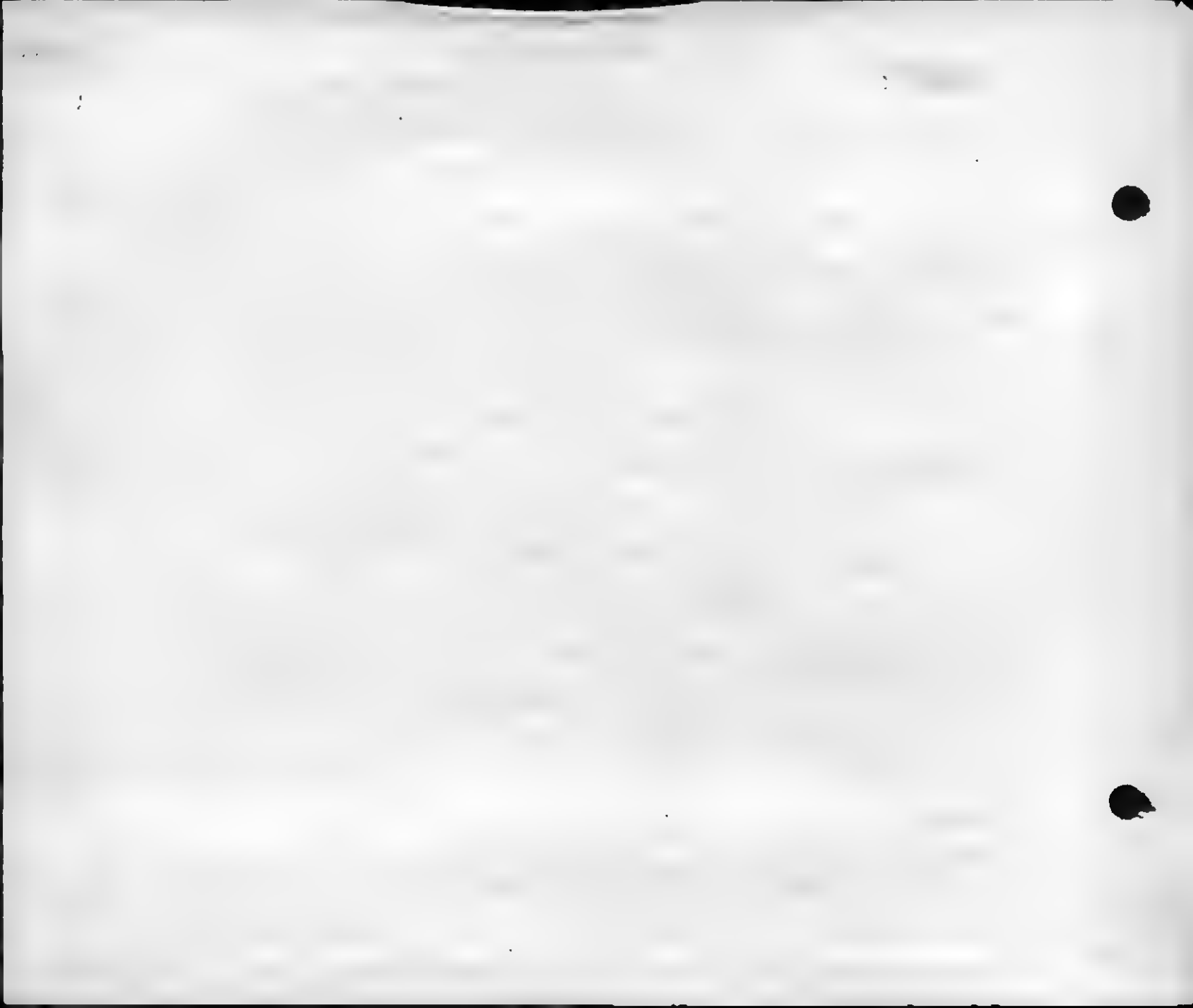
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>11</u> <u>11</u> <u>1966</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>3/5</u> 19 <u>50</u> to <u>11/5</u> 19 <u>66</u> , that I last saw the deceased alive on <u>11/1</u> 19 <u>66</u> , and that death occurred at <u>8 P</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	DATE SIGNED
ACTUAL SIGNATURE <u>W H Foard</u> M.D.		<u>25 N Main St</u>	
PHYSICIAN'S NAME (Type) <u>W. H. FOARD MD</u>		<u>Manchester, Md</u>	<u>11/5/66</u>

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/8/66</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Manchester</u>	22d. LOCATION (City, town, or county) (State) <u>Manchester Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Yipton-Edine</u>		ADDRESS <u>Hampstead, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>NOV 9</u> 19 <u>66</u>
		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or funeral home. After this certificate has been signed by the attending physician and completely filled in, the funeral director, TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or other disposition, and in any event, within 72 hours after death.

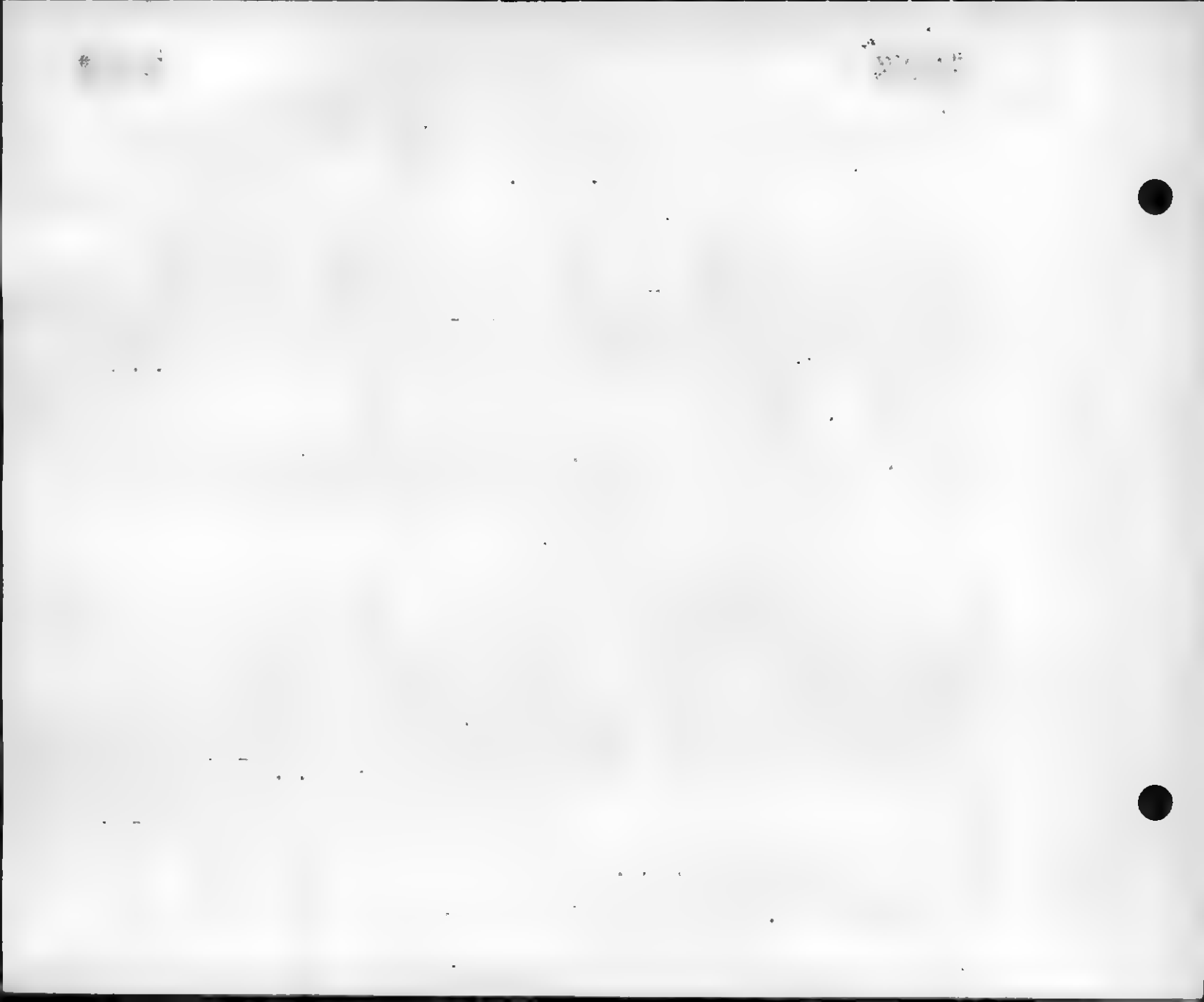
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15484

CERTIFICATE OF DEATH

15484

1 PLACE OF DEATH a COUNTY Carroll MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) a STATE Maryland b. COUNTY Washington					
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c LENGTH OF STAY IN 1b 4 mos. 3 dys.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock				
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d STREET ADDRESS Route #2		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last DANIEL OTHO MILLS				4. DATE OF DEATH Month Day Year November 11 1966					
5. SEX Male		6. CO. OR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 8-24-1884			
9 AGE (In years last birthday) 82		F UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad (retired)			10b. KIND OF BUSINESS OR INDUSTRY Railroad		11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James M. Mills				14. MOTHER'S MAIDEN NAME Mary Long					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unk.			16. SOCIAL SECURITY NO 213-16-1601-A		17 INFORMANT Records, Springfield State Hospital			Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Heart failure DUE TO (c) Arteriosclerotic heart disease							INTERVAL BETWEEN ONSET AND DEATH Days days years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 7-8-66 , to 11-11-66 , that (I) (we) last saw the deceased alive on 11-11-66 , and that death occurred at 8:45 P.M. from causes and on the date stated above									
22a. SIGNATURE Dr. Antonius Glahn, M.D.						22b. DATE SIGNED 11-11-66		22c. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D.	
23a. BURIAL, CREMATION, REMOVA (Specify) BURIAL			23b. DATE THEREOF 11.13.66		23c. NAME OF CEMETERY OR CREMATORY PARKHEAD E.U.B.		23d. LOCATION (City or town) (County) (State) BIG POOL WASHINGTON MD,		
24. FUNERAL DIRECTOR Howard Helton				ADDRESS Howard Helton		25a. REC'D BY REGISTRAR NOV 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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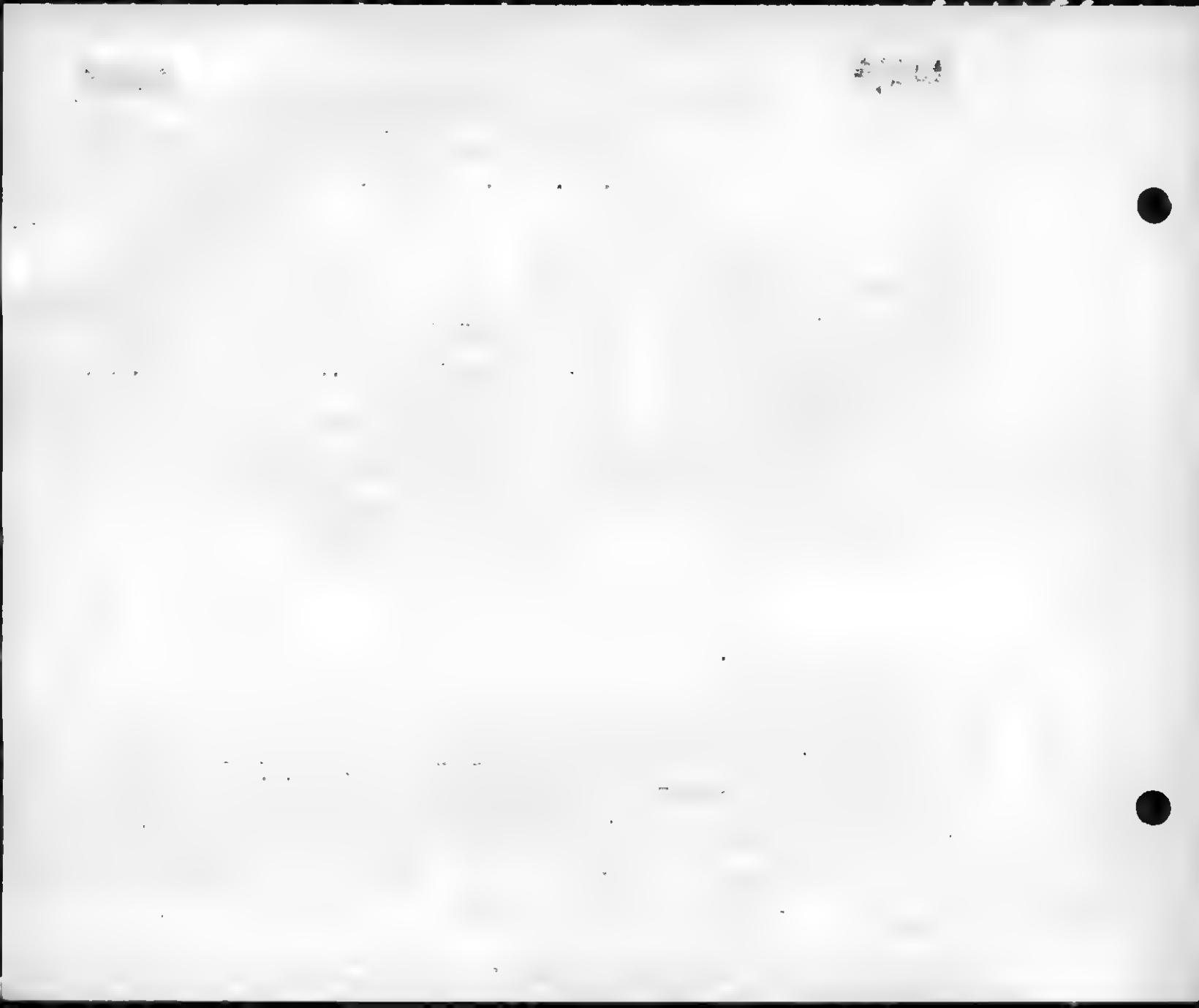
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15485

CERTIFICATE OF DEATH

15485

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>25yr. 2mo. 21dys.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>Unknown</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>NORA (N.N.) Agnes OWENS</u>				4. DATE OF DEATH Month Day Year <u>November 11 19 66</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8-14-00</u>	9. AGE (In years last birthday) <u>66</u> yrs	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eugene Davis</u>				14. MOTHER'S MAIDEN NAME <u>Rillie Dickson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>220-54-6591</u>		17. INFORMANT Address <u>Records, Springfield State Hospital</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pyogenic meningitis, organism unknown</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO (c) <u>Bilateral bronchopneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <u>Chronic brain syndrome associated with central nervous system syphilis, meningoencephalitic.</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-20-41</u> , 19 <u>41</u> to <u>11-11-66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11-11-66</u> 19 <u>66</u> , and that death occurred at <u>1:40 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Dr. Antonius Glahn</u> M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>11-11-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Antonius Glahn, M.D.</u>				22d. ADDRESS <u>Springfield State Hospital Sykesville, Maryland 21784</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/13/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetary</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown, Maryland</u>	
24. FUNERAL DIRECTOR <u>Rest Haven Funeral Chapel</u> ADDRESS <u>Hagerstown, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

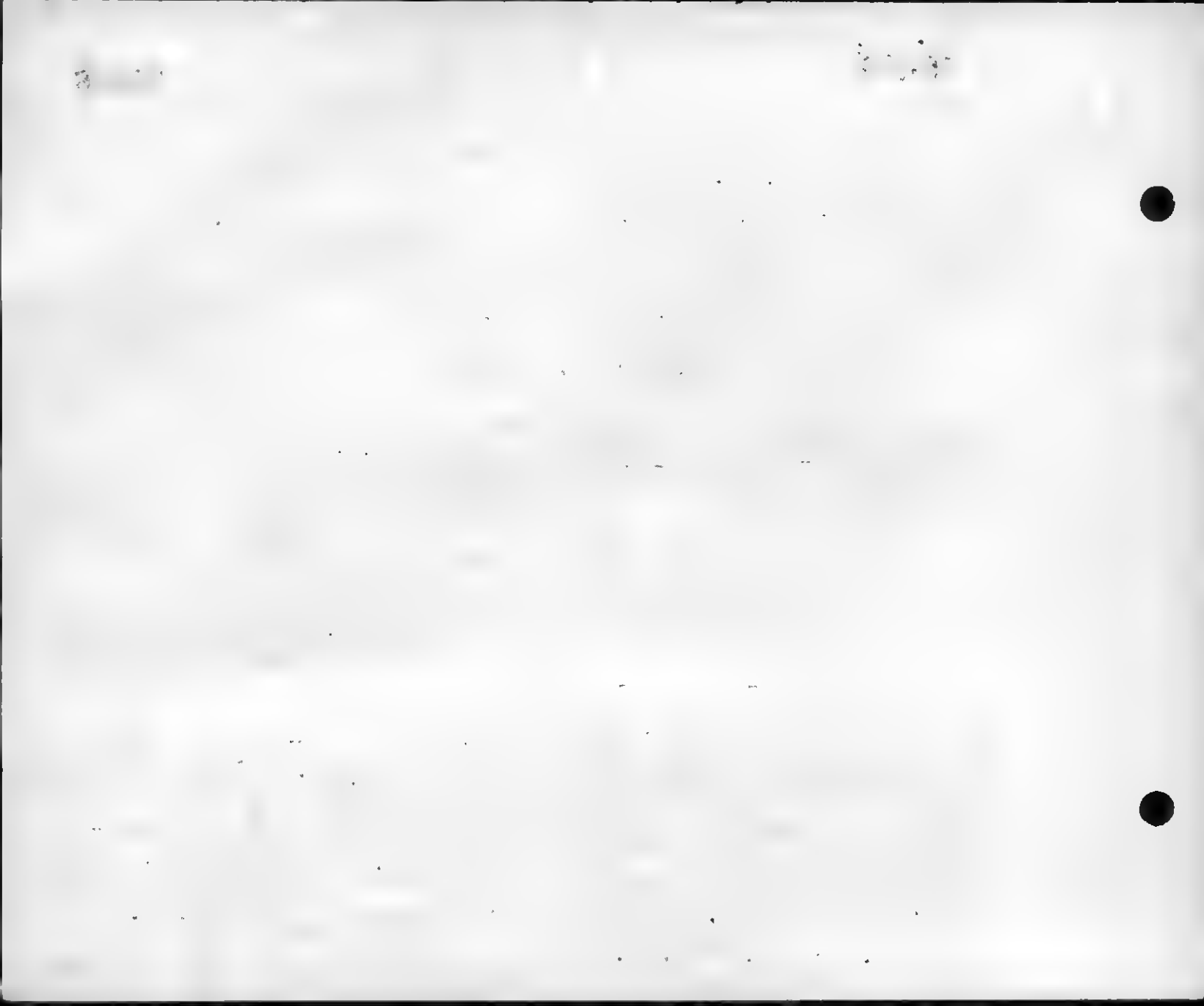
15486

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15486

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville, Md.		c. LENGTH OF STAY IN 1b 12y 7m 7d	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		d. STREET ADDRESS 1121 Gorsuch Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Harry Last Packham		4. DATE OF DEATH Month 11 Day 15 Year 19 66	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-9-1878
9. AGE (In years last birthday) yrs. 88		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY McCormack Co.	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis Packham		14. MOTHER'S MAIDEN NAME Elizabeth Sweeting	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes 1917-1919		16. SOCIAL SECURITY NO 218-10-6838 A	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinoma of Cecum DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRONCHOPNEUMONIA DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH years days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Chronic brain syndrome associated with disturbance of metabolism		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. -- p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from 4-8 , 19 54 to 11-15 , 19 66 , that (a) (we) last saw the deceased alive on 11-15 , 19 66 , and that death occurred at 2:05 M., from causes and on the date stated above.			
22a. SIGNATURE Frederic M. Labrit		22b. DATE SIGNED 11-15-66	
22c. PHYSICIAN'S NAME (Type) ALFREDO M. LABRIT		22d. ADDRESS Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/17/66.	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR NOV 17 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

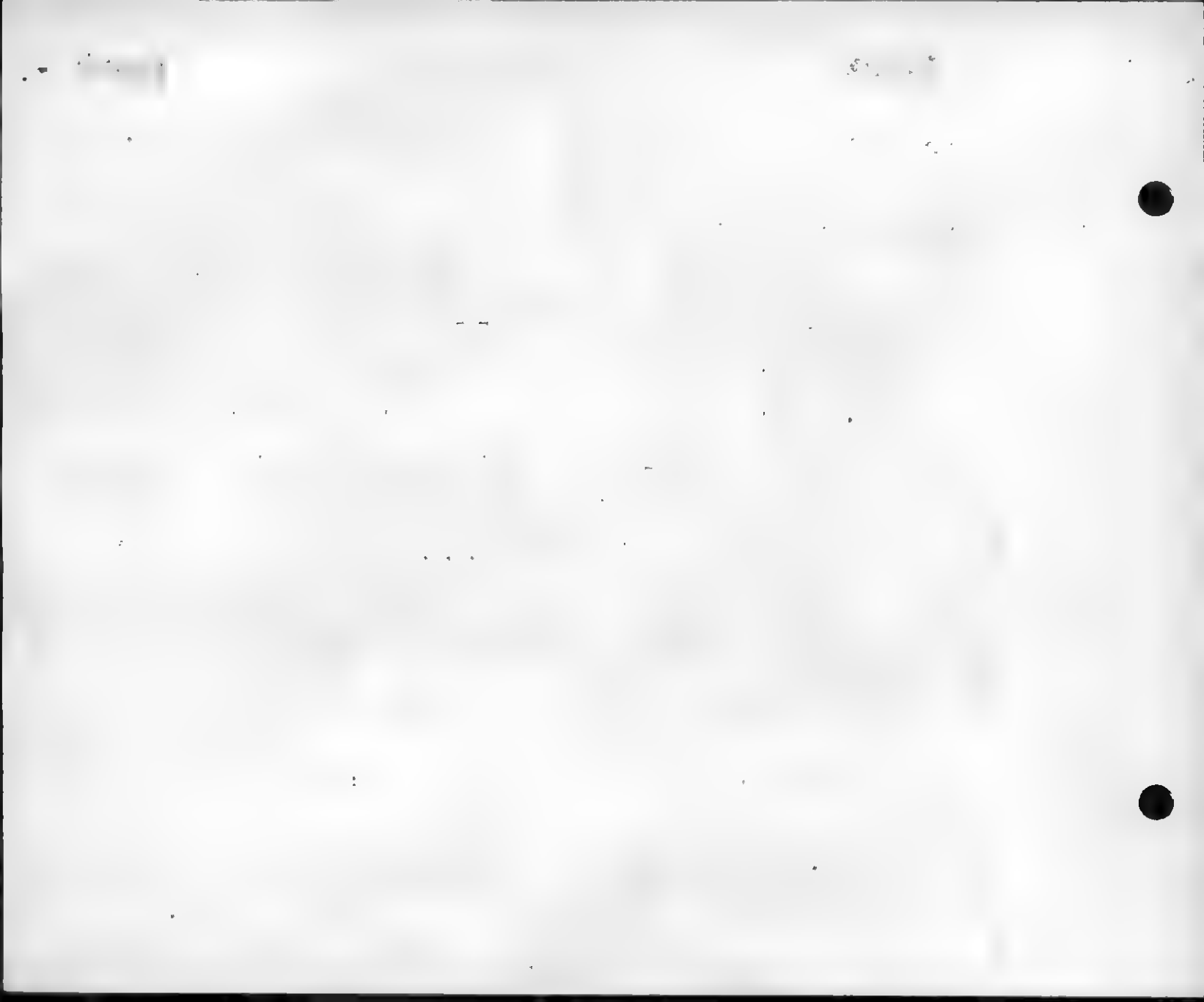
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15487

CERTIFICATE OF DEATH

15487

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 708 Harrington Road	
3. NAME OF DECEASED (Type or print) Lelia Virginia Pinkowski		4. DATE OF DEATH Month November Day 24 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-1-1889
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 15 Days 15 Hours 15 Min 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory worker		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry T. Minter		14. MOTHER'S MAIDEN NAME Gertrude Copeland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 578-14-6977	
17. INFORMANT Springfield State Hospital Records		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C.V.D. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS, With Cerebral Arteriosclerosis with Behavioral Reaction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/22/66 , 19__, to 11/24/66 , 19__, that (I) (we) last saw the deceased alive on 11/24/66 , 19__, and that death occurred at 8:45AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Dr. Antonius Glahn</i>		22b. DATE SIGNED 11/24/66	
22c. PHYSICIAN'S NAME (Type) Dr. Antonius Glahn		22d. ADDRESS Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/26/66	23c. NAME OF CEMETERY OR CREMATORY Parklawn	23d. LOCATION (City or Town) (County) (State) Rockville, Md.
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike		25. RECEIVED BY REGISTRAR DATE 20 1966	
26. REGISTRAR'S SIGNATURE <i>J. J. Judge</i>		27. REGISTRAR'S SIGNATURE <i>J. J. Judge</i>	



TO DEPUTY MEDICAL EXAMINER: This certificate must be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. (See Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.)

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

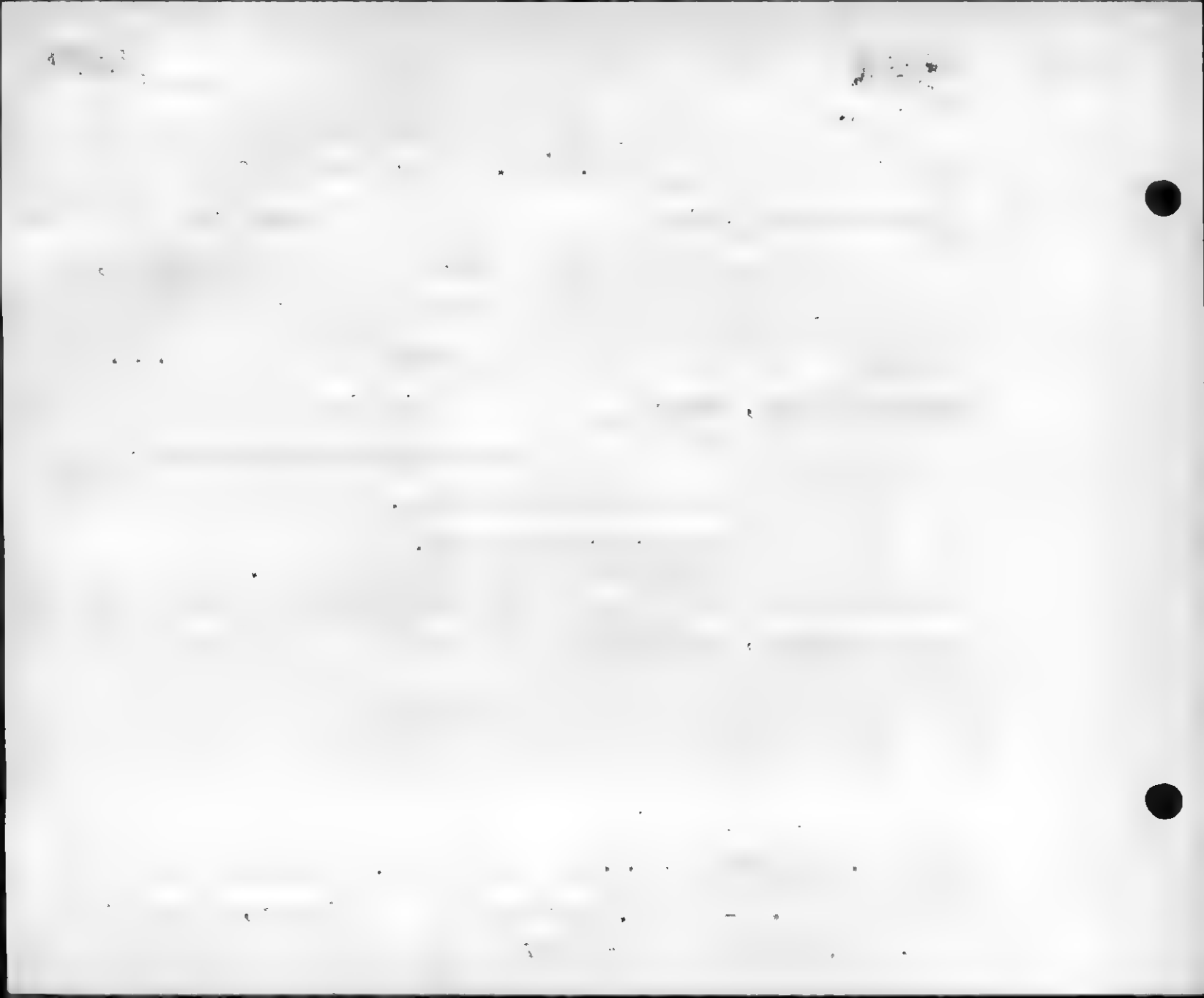
15488

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15488

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 10 days 11 yrs./8 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 3235 Elliott Street	
3. NAME OF DECEASED (Type or print) Theodore NMN RATAJCZAK		4. DATE OF DEATH Month November Day 19 Year 1966	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/21/12
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 1 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dependent		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Antoni Ratajczak		14. MOTHER'S MAIDEN NAME Pelagia Sobczak	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. NO	
17. INFORMANT Springfield State Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction. DUE TO (b) Coronary arteriosclerosis. DUE TO (c) Exposure to cold weather and starvation. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental deficiency, undifferentiated (deaf mute)		INTERVAL BETWEEN ONSET AND DEATH minutes weeks	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED while <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE W. Glenn Speicher, M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) W. Glenn Speicher, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 22-1966	
23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		23d. LOCATION (City, town or county) Baltimore, Maryland 21222	
24. FUNERAL DIRECTOR JOHN J. DUDA, Baltimore, Maryland 21222		25a. REC'D BY REGISTRAR NOV 23 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



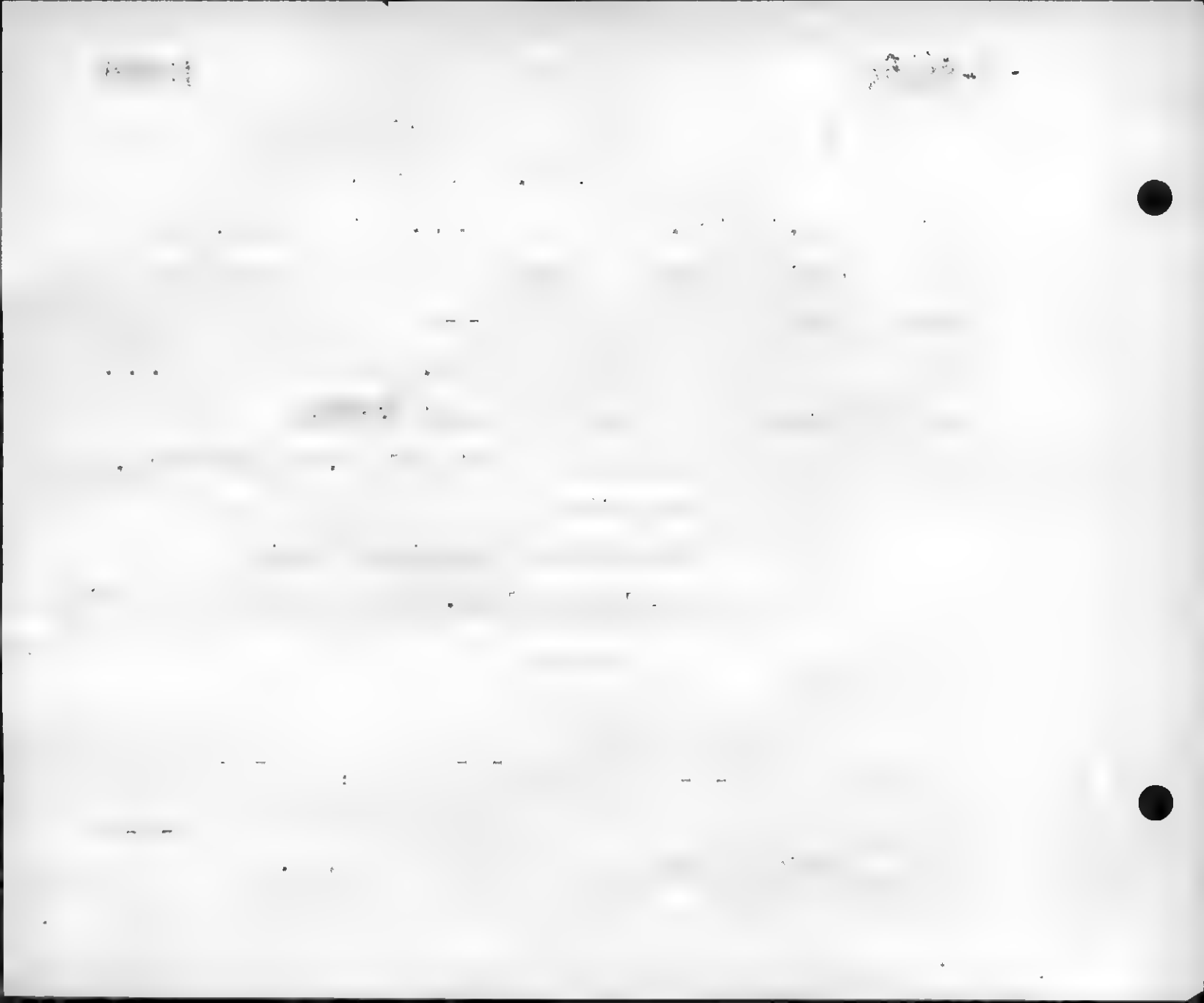
15489

CERTIFICATE OF DEATH

15489

1 PLACE OF DEATH a COUNTY Carroll MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b. COUNTY Allegany			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c LENGTH OF STAY in 1b 11yrs. 11mo.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield St. Hospital.				d STREET ADDRESS R.F.D. #1 Braddock Ave. LaVale		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Jessie Middle Maudie Last Resley				4 DATE OF DEATH Month November Day 20 Year 1966			
5 SEX Female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3-6-96		9 AGE (In years last birthday) 70	IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Own home		11 BIRTHPLACE (County & State, or foreign country) Md. Cumberland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William A Kirtley				14. MOTHER'S MAIDEN NAME Annie J. Deatlehauser			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO None		17. INFORMANT Springfield St. Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the Rectum with Metastasis DUE TO (c) to the liver and lungs.						INTERVAL BETWEEN ONSET AND DEATH years	
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-12-55 , 19__, to 11-20-66 , 19__, that (I) (we) last saw the deceased alive on 11-20-66 , 19__, and that death occurred at 12:50 AM , from causes and on the date stated above.							
22a. SIGNATURE Sergio W Palacio				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 11-20-66	
22c PHYSICIAN'S NAME (Type) Sergio W Palacio				22d ADDRESS Sykesville, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 11/23/66		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.	
24 FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland				25a REC'D BY REGISTRAR NOV 25 1966		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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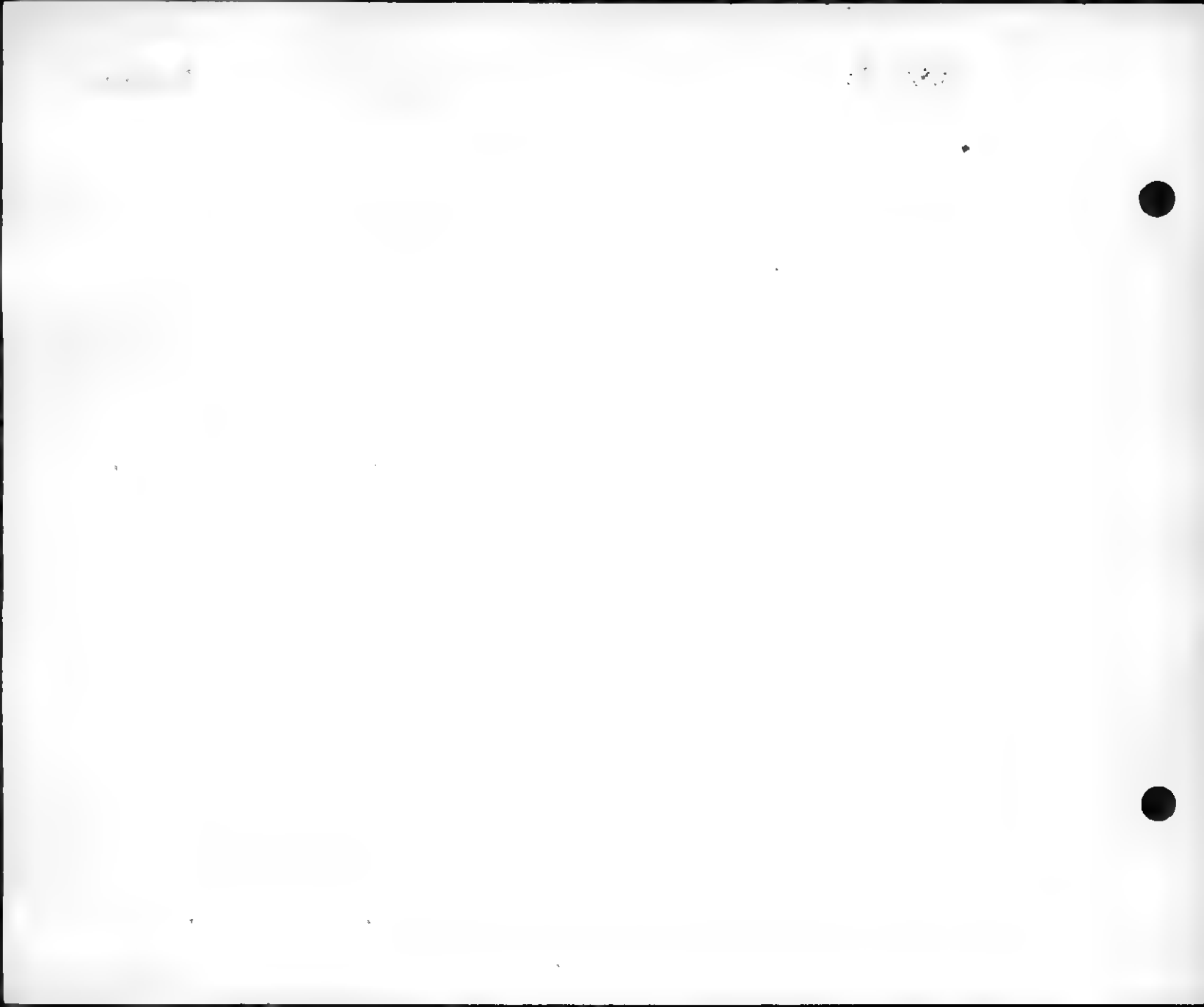
FOR STATE
HEALTH DEPT.

15490

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15490

1 PLACE OF DEATH a COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Carroll	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c LENGTH OF STAY IN 1b Manchester	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First BRET Middle RHOTON Last RHOTON		4 DATE OF DEATH Month November Day 30 Year 19 66	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8/18/66
9 AGE (In years, last birthday) yrs 3		10 IF UNDER 1 YEAR Months 3 Days 19 Hours 66 Min	
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b KIND OF BUSINESS OR INDUSTRY	
11c BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME James Rhoton		14 MOTHER'S MAIDEN NAME Joyce Bowers	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT James Rhoton, Manchester R.D.1 Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration 571.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Enteritis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty EXAMINER'S NAME (Type)		22. DATE SIGNED 11/30/66	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 12/2/66	23c NAME OF CEMETERY OR CREMATORY Lake View Mem. Park, Inc.
23d LOCATION (City or Town) (County) (State) Carroll Co. Md.		23e REC'D BY REGISTRAR DATE DEC 5 1966	
24 FUNERAL DIRECTOR Tipton-Eline		25b REGISTRAR'S SIGNATURE James Judge	



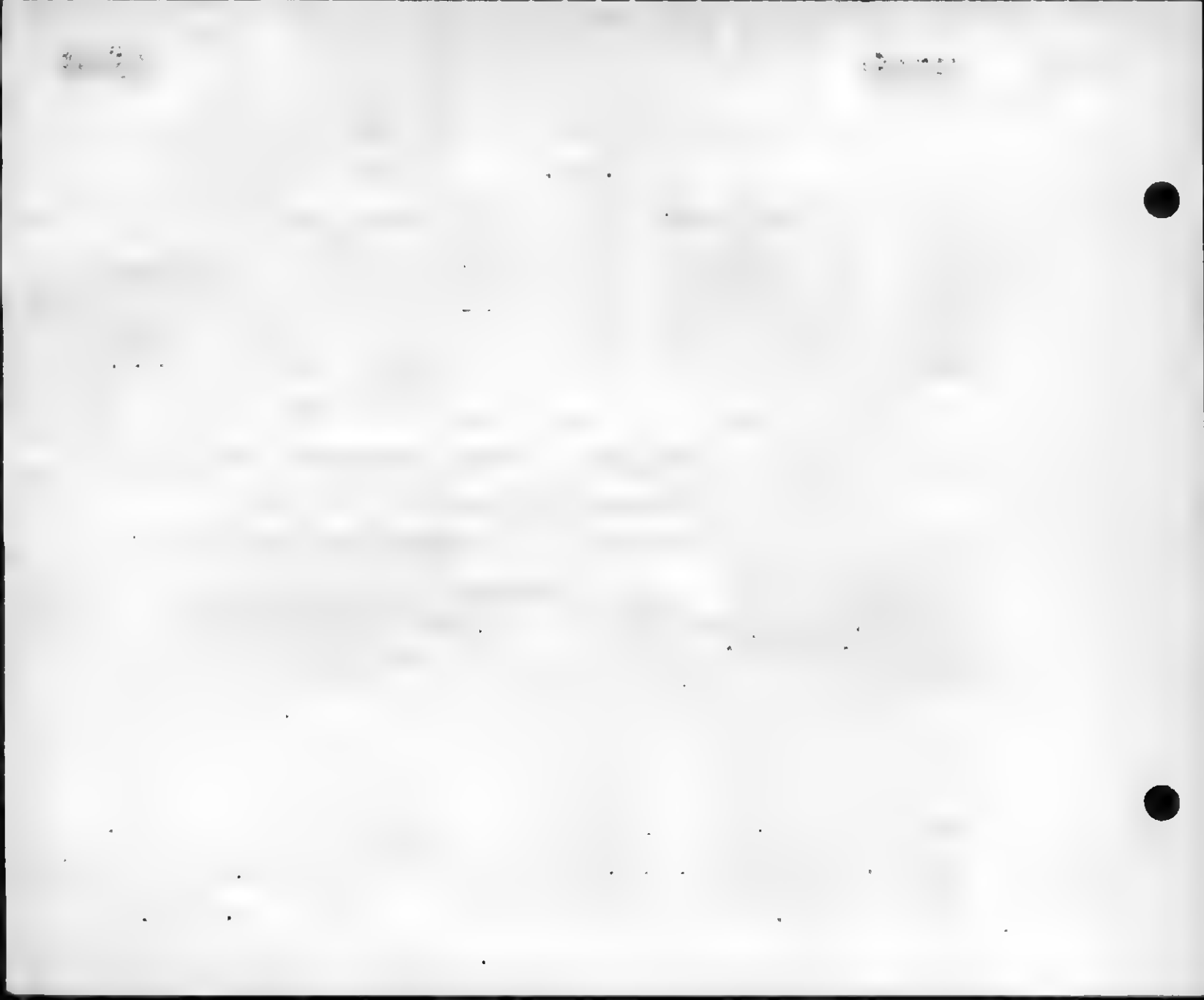
1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 15491

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 6mos. 8dys. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3200 Juneau Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle ELLEN Last RICHARDSON		4. DATE OF DEATH Month NOVEMBER Day 24 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-2-1884
9. AGE (In years last birthday) 82		10. IF UNDER 1 YEAR Months 11 Days 19 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Greer Kent		14. MOTHER'S MAIDEN NAME Alice Whiteford	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-50-2697	
17. INFORMANT Records, Springfield State Hospital		Address Springfield State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gram negative septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Secondary to acute suppurative hemorrhagic cystitis DUE TO (c) Secondary to decubitus ulcers, infected PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with cerebral arteriosclerosis, with psychotic reaction Fracture, left hip.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Injury occurred on Warfield	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 3:00 p.m. 9-25 19 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Springfield State Hospital		20f. (City or town) (County) (State) Sykesville Carroll Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. Glenn Speicher, M. D.		22. DATE SIGNED 11/24/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 27, 1966	
23c. NAME OF CEMETERY OR CREMATORY Slate Ridge		23d. LOCATION (City, town or county) (State) Delta, Penna.	
24. FUNERAL DIRECTOR John H. Harkins		25a. REC'D BY REGISTRAR NOV 29 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

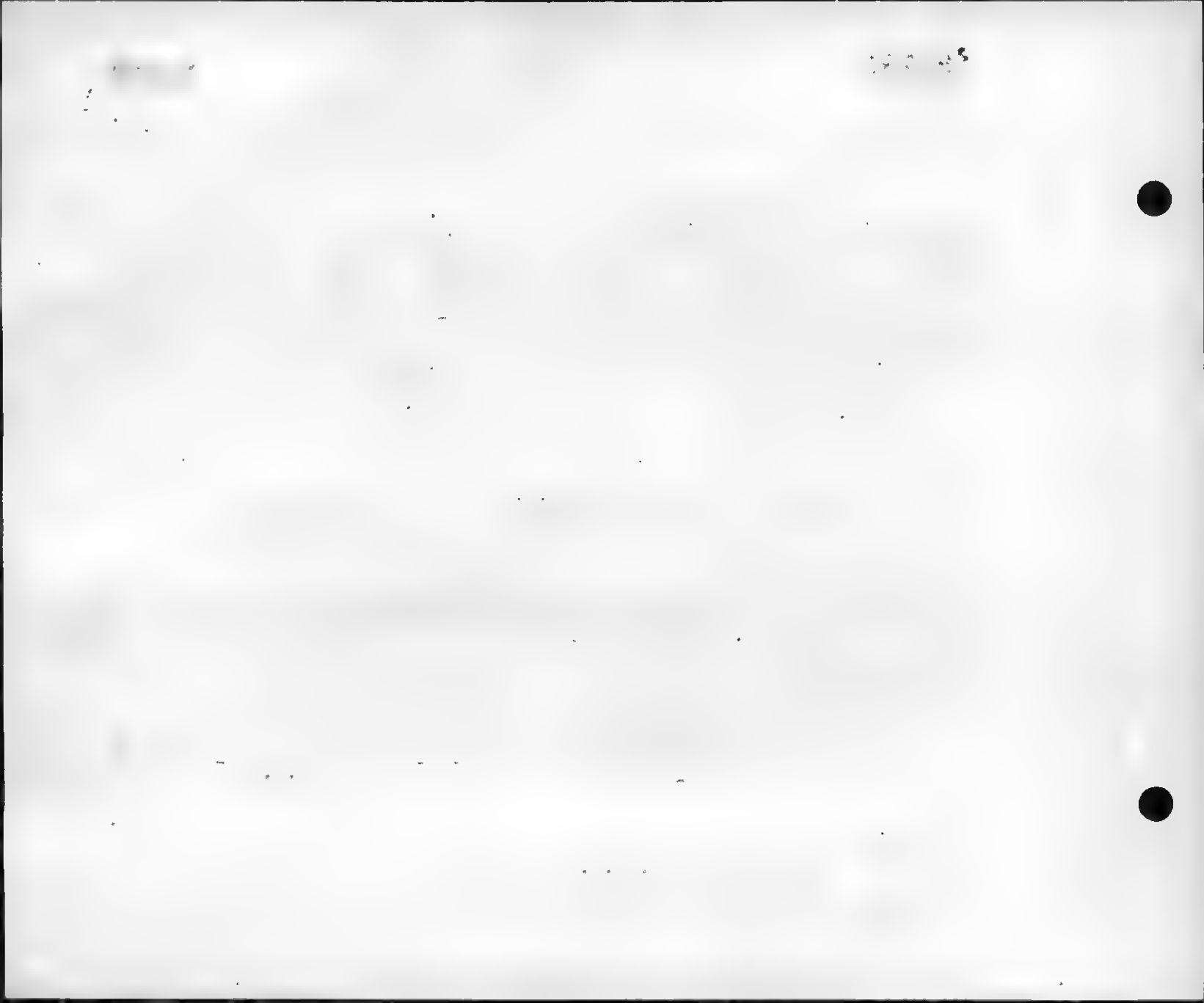
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



15492

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

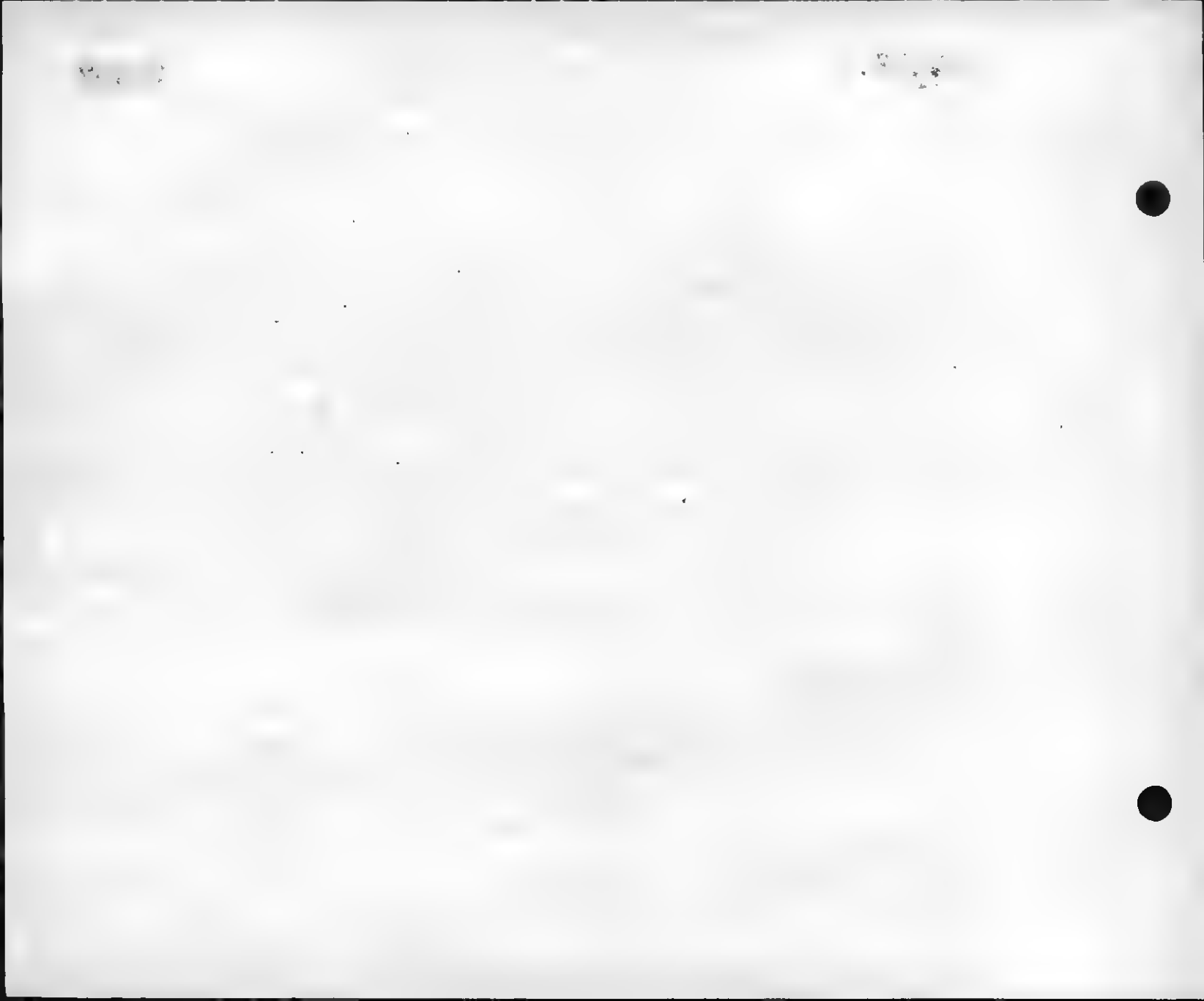
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15493

CERTIFICATE OF DEATH

15493

1 PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY in 1b <u>40 YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO. GEN. HOSPITAL</u>				a. STREET ADDRESS <u>46 CARROLL ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>ROLAND</u> Middle <u>McKINLEY</u> Last <u>SHIPLEY</u>				4 DATE OF DEATH Month <u>NOV.</u> Day <u>29</u> Year <u>1966</u>			
5 SEX <u>F.</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 24, 1898</u>		9 AGE (in years last birthday) <u>68</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN, ROAD CONTRACTORS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CARROLL CO. MD.</u>		11 BIRTHPLACE (County & State or foreign country) <u>U.S.A.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE A. SHIPLEY</u>				14. MOTHER'S MAIDEN NAME <u>EMILY J. WAGNER</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <u>NO</u>		16 SOCIAL SECURITY NO <u>216-03-6916A</u>		17 INFORMANT <u>MRS. ROLAND M SHIPLEY</u>		Address <u>SAME ADDRESS</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4/20/1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 2, 1966</u> , to <u>Nov 29, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov 29, 1966</u> , and that death occurred at <u>4 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>John S. Harshey</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/29/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>				22d. ADDRESS <u>8 Anchor St. Westminster, Md</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>12/1/66</u>		23c NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER CEMETERY</u>		23d LOCATION (City or Town) (County) (State) <u>WESTMINSTER, MD.</u>	
24. FUNERAL DIRECTOR <u>J. E. Myers, Jr., WESTMINSTER, MD.</u>				25a REC'D BY REGISTRAR DATE <u>DEC 1 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15494

CERTIFICATE OF DEATH

15494

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. LENGTH OF STAY IN 1b <u>2 DAYS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>UNION BRIDGE</u>			
3. NAME OF DECEASED (Type or print) <u>EDWARD EARL STULTZ</u>				4. DATE OF DEATH Month <u>11</u> Day <u>3</u> Year <u>1966</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 26, 1902</u>	9. AGE (In years lost birthday) <u>64</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHOVEL OPERATOR CEDENT CO.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (County & State or foreign country) <u>MARYLAND</u>		12. CIT ZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>EDWARD STULTZ</u>			14. MOTHER'S MAIDEN NAME <u>EFFIE BARNHART</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>216-05-1721</u>		17. INFORMANT <u>FLORENCE STULTZ</u> Address <u>UNION BRIDGE MD</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PULMONARY EMPHYSEMA - ADVANCED</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CHRONIC BRONCHITIS</u> (c) <u>COR PULMONALE</u>							INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/1</u> , 19 <u>66</u> , to <u>11/3</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/3</u> , 19 <u>66</u> , and that death occurred at <u>11:30</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>Vincent J. Flocco Jr.</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/3/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>VINCENT J. FLOCCO JR.</u>				22d. ADDRESS <u>WESTMINSTER MD</u>			
23a. BURIAL, CREMATON, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/6/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN</u>		23d. LOCATION (City or Town) (County) (State) <u>UNIONTOWN MD</u>	
24. FUNERAL DIRECTOR <u>W D Hartzler & Sons Union Bridge, Md</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 7 1966</u>		25b. REG STRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (When possible remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)



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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15495

CERTIFICATE OF DEATH

15495

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 8y. 1m. 30d.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield Hospital, Sykesville, Md.				d. STREET ADDRESS 12 W. Preston Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Lucretia Last Whdgemuth				4. DATE OF DEATH Month 11 Day 11 Year 1966			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-14-1881	9. AGE (In years last birthday) yrs. 85	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Marion Daneker				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-22-9455		17. INFORMANT Address Springfield Hospital, Sykesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia DUE TO (c) 4200						INTERVAL BETWEEN ONSET AND DEATH Years Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from 9-13- , 1958 , to 11-11-66 , that (a) (we) last saw the deceased alive on 11-11-1966 , and that death occurred at 4:40 a.m. from causes and on the date stated above.							
22a. SIGNATURE Ilse Kamm				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 11-11-66	
22c. PHYSICIAN'S NAME (Type) Dr. Ilse Kamm				22d. ADDRESS Springfield State Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-14-66		23c. NAME OF CEMETERY OR CREMATORY Cambridge Cemetery		23d. LOCATION (City or Town) (County) (State) Cambridge, Md.	
24. FUNERAL DIRECTOR Harry W. Knight				ADDRESS Sykesville, Md.		25a. REC'D BY REGISTRAR DATE NOV 15 1966	
				25b. REGISTRAR'S SIGNATURE J. Charles Judge			

7026

2242

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
15496						15496					
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Mt. Airy</u>				c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Mt. Airy</u> <u>16-1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R.D. 2</u>						d. STREET ADDRESS <u>R.D. 2</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Arthur Woodward</u>			First Middle Last			4. DATE OF DEATH <u>November 6 1966</u>			Month Day Year		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 30, 1904</u>		9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co., Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Arthur P. Woodward</u>						14. MOTHER'S MAIDEN NAME <u>Rachel Zepp</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-14-8774</u>		17. INFORMANT <u>Mrs. Viola M. Woodward</u> Address <u>Same As #2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>4201</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>55</u> , to <u>Nov</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>August 19 1966</u> , and that death occurred at <u>7:50</u> p.m. from the causes and on the date stated above.											
22a. SIGNATURE <u>W.B. Culwell</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>11/7/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>						22d. ADDRESS <u>900 S. Main St. Mt. Airy, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/9/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Poplar Springs</u>		23d. LOCATION (City, town or county) (State) <u>Howard Co., Md.</u>					
24. FUNERAL DIRECTOR <u>C. M. Waltz</u> Box 241 Sykesville, Md.						25a. REC'D BY REGISTRAR <u>NOV 10 1966</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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